
M E D I C A R E ANNUAL REPORT TO CONGRESS

Fiscal Year 1988

Including the Report on the
Medicare Validation Surveys of Hospitals
Accredited by
The Joint Commission of Accreditation
of Healthcare Organizations



U.S. Department of Health and Human Services
Health Care Financing Administration

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Introduction

Medicare is a Federal health insurance program for people age 65 or older, certain younger disabled people, and people of any age with permanent kidney failure. The program is administered by the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services (HHS).

Enacted into law in July 1965 and inaugurated a year later, Medicare has two parts: Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B). Hospital Insurance helps pay for medically necessary care provided by a Medicare-approved hospital, skilled nursing facility, home health agency, or hospice program. Supplementary Medical Insurance helps pay for medically necessary doctor services, outpatient hospital services, certain home health care, and various medical services and supplies not covered by Medicare Hospital Insurance.

Hospital Insurance is financed through the Federal Insurance Contributions Act (FICA) tax paid by employees, employers, and the self-employed. Supplementary Medical Insurance, which is voluntary, is financed from the monthly premiums paid by enrollees and from Federal general revenues.

Payments for services and supplies provided to Medicare beneficiaries are made through private insurance organizations under contract with HCFA. Hospital Insurance claims are handled by Medicare "intermediaries" and Supplementary Medical Insurance claims by Medicare "carriers."

Medicare benefit payments are reflected in the national health expenditures, which, in Calendar Year (CY) 1988, totaled \$539.9 billion, an increase of 10.4 percent over 1987. Medicare benefit outlays totaled \$85.5 billion in Fiscal Year (FY) 1988, an increase of 6.9 percent. Medicare accounted for 18 percent of all personal health care expenditures in the country in CY 1988, including 27 percent of all hospital bills and 22 percent of all payments for physician services.

National health expenditures in 1988 accounted for 11.1 percent of the gross national product, up from 9.1 percent in 1980, 7.3 percent in 1970, and 5.3 percent in 1960. Per capita spending increased to a level of \$2,124, or about 10 times the per capita spending of 1965.

Abbreviations and Acronyms

AAPCC	Adjusted average per capita cost	ICA	Internal control areas
AIDS	Acquired immune deficiency syndrome	ICN	Inventory control number
ALICO	Amalgamated Life Insurance Company of America	JCAHO	Joint Commission on Accreditation of Healthcare Organizations
ALJ	Administrative law judge	LSC	Life Safety Code
AMA	American Medical Association	MAAC	Maximum allowable actual charge
APPS	Automated Plan Payment System	MAF	Medical assistance facilities
ASC	Ambulatory surgery center	MEDPAR	Medicare provider analysis and review
ATB	All trunks busy	MIGs	Medicare insured groups
CABG	Coronary artery bypass grafts	MSP	Medicare Secondary Payer Program
CAP	College of American Pathologists	NAIC	National Association of Insurance Commissioners
CMI	Case Mix Index	NFPA	National Fire Protection Association
CMP	Competitive medical plan	NTIS	National Technical Information Services
COBRA	Consolidated Omnibus Budget Reconciliation Act	OBRA	Omnibus Budget Reconciliation Act
COP	Conditions of participation	OMB	Office of Management and Budget
CPEP	Contractor performance evaluation program	OPA	Office of Public Affairs
CPI	Consumer Price Index	OPM	Office of Personnel Management
CPT	Claims processing timeliness	ORD	Office of Research and Demonstrations
CWF	Common working file	PICS	Plan Information Control System
DCG	Diagnostic cost group	PIP	Periodic interim payment
DEFRA	Deficit Reduction Act	P.L.	Public law
DME	Durable medical equipment	PMI	Presidential management intern
DOLA	Delegation of leasing authority	PPO	Preferred provider organization
DRG	Diagnosis related group	PPS	Prospective payment system
EAP	Employee Assistance Program	PRO	Peer review organization
EMC	Electronic media claim	QAR	Quality assurance review
ESRD	End-stage renal disease	QRO	Quality review organization
FI	Fiscal intermediary	R&D	Research and demonstrations
FICA	Federal Insurance Contributions Act	SA	State agencies
FSES	Fire Safety Evaluation System	SMI	Supplementary Medical Insurance (Medicare Part B)
FY	Fiscal year	SNF	Skilled nursing facility
GHPS	Group health plan system	SSA	Social Security Administration
GNP	Gross National Product	TEFRA	Tax Equity and Fiscal Responsibility Act
GSA	General Services Administration	TENS	Transcutaneous electrical nerve stimulators
HCFA	Health Care Financing Administration	TURPS	Transurethral resection prostatectomies
HCPP	Health care prepayment plan		
HHA	Home health agency		
HHS	U.S. Department of Health and Human Services		
HI	Hospital insurance (Medicare Part A)		
HMO	Health maintenance organization		
ICF	Intermediate care facility		

Executive Summary

Beneficiaries

During Fiscal Year (FY) 1988 the number of Medicare beneficiaries increased by approximately 569,000, from 32.4 million to nearly 33 million (Table 1). About 499,000 of the new beneficiaries were 65 years of age and older, bringing to about 29.9 million the number of elderly enrolled in Medicare; 71,000 were younger disabled persons, boosting the number of disabled beneficiaries to 3.1 million. Of the total number of beneficiaries, 32.3 million were residents of the United States, 423,000 lived in U.S. commonwealths and territories, and 260,000 resided in other countries.

Fully 94.4 percent (28.2 million) of the aged and 91.5 percent (2.8 million) of the disabled were enrolled in both Medicare Hospital Insurance (Part A) and Medicare Supplementary Medical Insurance (Part B). Approximately 95.2 percent of the Medicare enrollees residing in the 50 States and the District of Columbia were covered by both parts (Table 2).

Benefit Payments

Medicare benefit payments totaled about \$85.5 billion in FY 1988, or 7.3 percent more than the benefit outlays for the previous fiscal year (Table 3). Benefits paid under the Hospital Insurance (HI) program amounted to \$51.9 billion, while those paid under the Supplementary Medical Insurance (SMI) program totaled \$33.7 billion. Inpatient hospital care accounted for \$48.7 billion, or 94 percent, of Part A spending while 4 percent went for home health care, and about 1.4 percent for skilled nursing facility (SNF) care. The balance was spent on hospice care. Physician services accounted for 72 percent of Part B spending, an 11 percent increase over the previous fiscal year. Outpatient services

accounted for 19.2 percent of Part B spending, home health care and prepayment plans for 6 percent, and independent laboratories for 2.9 percent.

Program Funding

In FY 1988, 91 percent of the financing for Medicare Part A was derived from employment taxes paid by workers and their employers and by self-employed individuals. The remainder came from Federal general revenues and other sources. Part B was financed by three sources: (1) premium payments from enrollees (25 percent); (2) contributions from general revenues (73 percent); and (3) interest on balances in the SMI Trust Fund (2 percent). The Part B monthly premium was \$24.80.

Health Care Providers

At the close of the fiscal year, 5,800 short-stay and 283 long-stay hospitals with about 1.02 million beds were participating in Medicare (Table 4), as were 7,507 skilled nursing facilities (SNFs), 146 comprehensive outpatient rehabilitation facilities, 5,688 home health agencies (HHAs), and 4,571 independent laboratories. Other participating health care providers included 950 ambulatory surgical centers, 522 hospices, 450 rural health clinics and 1,755 end-stage renal disease (ESRD) facilities or units providing services to Medicare beneficiaries requiring maintenance dialysis or kidney transplants (Table 5).

Participating Physicians and Suppliers

About 40.7 percent of the physicians (283,475) and 21 percent of the medical suppliers (24,938) serving Medicare beneficiaries signed participation agreements with the Health Care Financing Administration (HCFA) for the 1988 calendar year. Physi-

cians and suppliers may make a voluntary choice each year to participate in Medicare and to accept assignment on all Medicare claims. Participating physicians and suppliers agree to accept Medicare approved amounts as payment in full for their services regardless of the actual charges. Beneficiaries are responsible only for applicable deductible and coinsurance amounts.

Quality of Care Monitored

Peer review organizations (PROs) under the aegis of HCFA concentrated during the fiscal year on monitoring the quality of care afforded Medicare beneficiaries and ensuring compliance by Medicare providers with the provisions of the prospective payment system (PPS). Major areas scrutinized by the PROs included hospital admissions, readmissions and transfers, accuracy of coding, and day and cost outlier cases. Data compiled for the period October 1987 to September 1988 indicate that PROs identified 24,969 physicians and 804 hospitals with possible quality-of-care problems. PROs further cited 266 physicians and 53 providers for potential substantial or gross and flagrant violations of Medicare standards. During the same period, PROs reported that 9,465 Medicare patients were discharged prematurely or were readmitted for care that should have been provided during the first admission.

Prepayment Plan Option

HCFA maintained emphasis throughout the year on the importance of providing Medicare beneficiaries with an alternative to traditional fee-for-service health care by promoting prepayment health plans as an option that beneficiaries should consider in determining how they will receive Medicare-covered services. By the end of the fiscal year, the number of health maintenance organizations (HMOs), competitive medical plans (CMPs), and health care prepayment plans (HCPPS)

under contract with HCFA decreased from 245 to 227, and the number of beneficiaries enrolled in prepayment plans dipped from 1,795,958 to 1,782,590. While the number of beneficiaries enrolled in plans of all types declined, the number of enrollees in plans that had risk-based contracts with HCFA increased from 1,062,914 to 1,112,158.

Preferred Provider Organization Demonstration

To further expand the types of health care delivery systems available to beneficiaries, HCFA developed plans for a preferred provider organization (PPO) demonstration. The intent is to assess the cost-effectiveness of PPO arrangements in controlling the volume of Medicare services performed or ordered by physicians. The agency also implemented a comprehensive monitoring program during the fiscal year, with staffs in the central office and 10 regional offices employing the program on-site at 60 HMOs/CMPs to evaluate their compliance with statutory and contractual requirements.

Contract with Finlay Medical Centers Terminated

A 3-year-old demonstration contract with Finlay Medical Centers in Miami, Florida, was terminated during the fiscal year because of problems and inadequate protection against the risk of insolvency. The Florida State Department of Insurance subsequently initiated insolvency proceedings which led to the corporate dissolution of Finlay Medical Centers. HCFA implemented a plan to provide for a smooth transition to other coverage for Medicare beneficiaries who had been enrolled in Finlay.

Medicare Claims and Beneficiary and Provider Inquiries

Medicare intermediaries received 72 million claims in FY 1988, a 7.2 percent

increase over FY 1987, and Medicare carriers received 378.3 million, for a 13.1 percent increase. More than 52 million of the claims processed by intermediaries and about 129 million processed by carriers were transmitted electronically.

Both Part A and Part B Medicare contractors were required as of the beginning of FY 1988 to pay at least 95 percent of all "clean" claims from Medicare participating physicians within 19 days, 95 percent of all other clean claims within 26 days, 95 percent of all claims within 60 days, and 99 percent within 90 days. By the end of the fiscal year nearly all contractors had met the claims processing timeliness (CPT) deadlines. During the same period, Medicare carriers handled 16,738,255 beneficiary inquiries, while Medicare intermediaries handled 1,699,425. In addition, carriers handled 7,161,169 provider inquiries.

Payments Limited to Hospitals for Certain Diagnostic Procedures

HCFA implemented Section 9343 of the Omnibus Budget Reconciliation ACT of 1986 (OBRA 86) which enacted section 1833(i)(3) of the Social Security Act (the Act) to place a payment limitation on hospitals for certain diagnostic procedures. Payment for these procedures must be based, in part, on what Medicare would have paid for the same procedure had it been performed in an ambulatory surgical center.

Operational and Carrier Medical Reviews

Operational reviews undertaken during the fiscal year included a review of the effectiveness of nationally mandated and local carrier review screens, and a review of the medical necessity and reasonableness of payments for certain Medicare hospital outpatient services. An ongoing review of physician global service package studies for selected surgeries was continued in FY 1988, and four new global

service package studies were started. Ensuring that Medicare payment is made only for reasonable and necessary physician services is the responsibility of the Medicare carriers. Carriers execute this responsibility through a blend of prepayment reviews of utilization patterns of physician and supplier services. The carrier determination is based on national coverage policy in association with local policy developed by the carrier medical staff. This activity has been cost-effective, with FY 1988 program savings of about \$10 for each administrative dollar expended.

Medicare Secondary Payer Provisions

The Medicare secondary payer (MSP) provisions, which cost \$64 million to administer, produced more than \$1.4 billion in savings. The provisions determine when Medicare is a secondary payer and another insurer is the primary payer of a Medicare beneficiary's claims for covered medical services and supplies. Other Medicare payment safeguards accounted for \$2.8 billion in savings during the fiscal year.

Contractor Performance Evaluation Program

The Contractor Performance Evaluation Program (CPEP) contains performance standards designed to prevent the inappropriate expenditure of Medicare funds. Thirty-one Part A and 29 Part B standards were applied during FY 1988 to evaluate contractor performance with regard to payment safeguards. All 57 Medicare intermediaries and 41 of 48 Medicare carriers met the CPEP standards in FY 1988. The seven carriers that failed to meet the standards were required to implement plans to improve their performance.

Replacement Contractors

In April 1988, Prudential Insurance Company announced its intention not to renew its Medicare contracts effective December 1988.

For the Part A workloads, Blue Cross Blue Shield United of Wisconsin was selected to serve as the designated regional home health intermediary in the New York region, comprising New York, New Jersey, Puerto Rico, and the Virgin Islands. The New Jersey hospital and skilled nursing facility workloads were reassigned to Blue Cross and Blue Shield of New Jersey, Inc., and Aetna Life and Casualty Company. For the Part B workloads, Pennsylvania Blue Shield was selected as the Medicare carrier for New Jersey, Equicor Inc. for North Carolina, and Aetna Life and Casualty Company for Georgia.

Medicare Hospital Mortality Information

The Department of Health and Human Services (HHS) released to the public the first annual Medicare Hospital Mortality Information Report (1986). The seven volume report, prepared by HCFA using information extracted from the Hospital Discharge File, detailed the calendar year 1986 mortality rates and the expected mortality ranges for all Medicare patients with an admission to a Medicare-certified hospital in the United States during that year. The rates and ranges were reported for all causes and for 16 diagnostic categories.

Expanded Medicare Coverage

Medicare benefits were expanded in FY 1988 to include coverage for clinical psychologist services rendered at community mental health centers, and immunosuppressive drugs required during the first year after an organ transplantation.

Research, Demonstrations, and Evaluations

Research, demonstration, and evaluation projects were conducted during the fiscal year in the areas of hospital payment, physician payment, State programs for long-term care, alternative payment systems, program analysis

and evaluation, quality and coverage, and beneficiary awareness and preventive care. Besides funding various intramural projects, HCFA spent nearly \$29 million in FY 1988 for research and demonstration (R&D) grants and contracts in seven program areas. About \$17 million went to the approximately 150 studies that continued into FY 1988 from previous years and \$12 million went to fund 95 new projects.

Internal Control and Recruiting Programs Stressed

HCFA management initiatives during the fiscal year included implementation of the delegation of leasing authority (DOLA) for six additional buildings occupied by HCFA in Baltimore, Maryland, improvement to the agency's internal control program, and intensified efforts to attract highly qualified job applicants. FY 1988 departmental procurement preference and competition goals were met or nearly met in six categories in the awarding of more than \$1.1 million in contracts.

New Laws Require Significant Changes in Medicare

Two major pieces of legislation were enacted during FY 1988 that will greatly impact the Medicare program. One, the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) called for a series of changes largely aimed at slowing the rate of growth of Medicare expenditures. The other, the Medicare Catastrophic Coverage Act of 1988 (MCCA of 88) mandated the largest expansion of the Medicare program since its inception in 1966. MCCA is intended to protect the elderly and disabled from financial hardship in the event of catastrophic illness by expanding Medicare coverage. The additional benefits are to be paid for by an addition to the basic monthly Part B premium and a new annual income-tax-related premium.

Several New Regulations Published

Proposed new rules published in the Federal Register during FY 1988 included one that is intended to enhance the organ procurement process by establishing standards and conditions covering organ procurement organizations. A second proposed rule would establish regulatory standards and conditions for hemodialyzer reuse and reprocessing, and a third would make changes in periodic interim payments to hospitals and other providers. A proposed rule updating and clarifying provisions of the Medicare Secondary Payer Program was also published, as was a proposed rule affecting the valuation of assets acquired by certain health care facilities as the result of changes in ownership.

Validation Surveys of Hospitals

The purpose of the Medicare validation program is to determine the effectiveness of the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) accreditation process in providing reasonable assurance that hospitals comply with the intent of the Medicare conditions of participation. Each year a statistical sample of the approxi-

mately 5,200 Joint Commission accredited hospitals is selected for validation surveys. Under contract with the Secretary of the Department of Health and Human Services, Medicare State survey agencies (SAs) conducted 98 validation surveys during fiscal year 1988.

HCFA's validation analysis was conducted in two areas: Life Safety Code (LSC) and general health and safety requirements. The LSC of the National Fire Protection Association is a consensus standard adopted by reference in Federal regulations that provides a reasonable level of safety from fire and emergencies. During the fiscal year, 67.3 percent (66 of 98) of validated hospitals were in compliance with general health and safety conditions.

In addition to the surveys conducted at selected hospitals, other accredited hospitals are subject to an SA survey when there is an allegation that significant deficiencies threaten the health and safety of their patients. For this report period, 233 hospitals received allegation investigations, and 13 percent (30 of 233) were found out of compliance with one or more conditions.

Table 1

ALMOST 33 MILLION PERSONS HAVE SOME MEDICARE COVERAGE

YEAR	TOTAL	A G E D			D I S A B L E D		
		TOTAL	8 5 & O V E R		TOTAL	ESRD ONLY	ALL ESRD
			NUMBER	PERCENT			
1988	32,980	29,879	3,102	10.4	3,101	53	141
1987	32,411	29,380	3,024	10.3	3,031	47	131
1986	31,749	28,791	2,932	10.2	2,959	39	120
1985	31,083	28,176	2,861	10.2	2,907	31	103
1984	30,455	27,571	2,778	10.1	2,884	30	98
1980	28,478	25,515	2,410	9.4	2,963	28	67
1973	23,545	21,815	1,699	7.8	1,731	6	10
1966	19,109	19,109	1,183	6.2	—	—	—

¹Sum of aged with ESRD, disabled with ESRD, and those entitled because of ESRD only (Section 226A of the Social Security Act).

NOTE: Total enrollees residing in U.S., in territories and possessions, and in foreign countries.

Table 2

MEDICARE TOUCHES MORE AND MORE PEOPLE: ONE OUT OF EIGHT HAS SOME MEDICARE COVERAGE OVER 95 PERCENT OF THE U.S. MEDICARE POPULATION IS ENTITLED TO BOTH HI AND SMI

PROGRAM COVERAGE	A L L A R E A S			U . S .			P O S S E S S I O N S & T E R R I T O R I E S			F O R E I G N C O U N T R I E S		
	TOTAL	AGED	DISABLED	TOTAL	AGED	DISABLED	TOTAL	AGED	DISABLED	TOTAL	AGED	DISABLED
HI and/or SMI ¹	32,980	29,879	3,101	32,297	29,302	2,995	423	330	92	260	246	14
HI	32,413	29,312	3,101	31,732	28,737	2,995	421	329	92	260	246	14
SMI	31,617	28,780	2,837	31,297	28,512	2,785	275	227	49	44	41	4
HI and SMI	31,050	28,213	2,837	30,732	27,947	2,785	274	226	49	44	41	4
HI only	1,363	1,098	265	1,000	790	210	147	103	44	216	205	10
SMI only	567	567	(²)	566	566	(²)	1	1	(²)	(²)	(²)	(²)

¹ Unduplicated count of persons enrolled in one or both parts of the Medicare program.

² Less than 500.

Table 3.

MEDICARE BENEFIT PAYMENTS SHIFT TO PART B SERVICES

FISCAL YEAR	TOTAL MEDICARE	TOTAL HOSPITAL INSURANCE	TOTAL MEDICARE	INPATIENT SNF	HHA	HOSPICE	TOTAL SUPPLEMENTARY MEDICAL INSURANCE	PHYSICIAN AND INDEPENDENT LABORATORY	OUTPATIENT
BENEFIT PAYMENTS IN MILLIONS									
1988	85,540	51,858	48,770	712	2,239	137	33,682	25,218	6,452
1987	79,750	49,813	46,830	616	2,263	104	29,937	22,772	5,780
1986	74,036	48,867	46,034	579	2,186	68	25,169	19,248	4,920
1985	69,518	47,710	44,988	570	2,118	34	21,808	17,281	3,903
1984	60,934	41,461	39,080	536	1,841	4	19,473	15,449	3,534
1983	55,589	38,102	36,075	511	1,516	0	17,487	13,708	3,346
PERCENT DISTRIBUTION									
1988	100.0	60.6	57.0	0.8	2.6	0.16	39.4	29.5	7.5
1987	100.0	62.5	58.7	0.8	2.8	0.13	37.5	28.6	7.2
1986	100.0	66.0	62.2	0.8	3.0	0.09	34.0	26.0	6.6
1985	100.0	68.6	64.7	0.8	3.0	0.05	31.4	24.9	5.6
1984	100.0	68.0	64.1	0.9	3.0	0.01	32.0	25.4	5.8
1983	100.0	68.5	64.9	0.9	2.7	0.00	31.5	24.7	6.0
BENEFIT PAYMENTS PER ENROLLEE									
1988	2,594	1,600	1,505	22	69	4	1,065	798	204
1987	2,461	1,564	1,470	19	71	3	960	731	185
1986	2,332	1,565	1,475	19	70	2	823	629	161
1985	2,237	1,560	1,471	19	69	1	727	576	130
1984	2,001	1,382	1,303	18	61	0	662	525	120
1983	1,851	1,288	1,219	17	51	0	604	473	115
PERCENT CHANGE IN BENEFIT PAYMENTS FROM PRIOR YEAR									
1988	5.4	2.3	2.3	13.6	-2.8	29.5	10.9	9.2	10.0
1987	5.5	-0.1	-0.3	4.3	1.5	49.9	16.7	16.1	15.3
1986	4.3	0.4	0.3	-0.5	1.1	96.0	13.1	9.2	23.6
1985	11.8	12.8	12.9	4.3	12.8	733.5	9.8	9.7	8.3
1984	8.1	7.3	6.9	3.5	19.8	N/A	9.7	11.0	4.0
1983	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

SOURCE: Office of the Actuary.

Table 4

AFTER PERIOD OF SLOW GROWTH, NUMBER OF BEDS DECREASED IN 1988

	1975	1980	1985	1986	1987	1988
Total Hospitals	6,773	6,777	6,707	6,720	6,677	6,687
Beds (in thousands)	1,140	1,150	1,144	1,146	1,177	1,118
Beds per 1,000 Enrollees	51.7	46.7	42.5	40.9	41.3	39.1
Short-Stay	6,107	6,104	6,034	5,994	5,872	5,800
Beds (in thousands)	902	991	1,027	1,026	1,038	991
Beds per 1,000 Enrollees	40.9	40.2	38.2	36.6	36.4	34.7
Psychiatric	385	408	474	509	604	604
Beds (in thousands)	199	131	95	97	115	94
Beds per 1,000 Enrollees	9.0	5.3	3.5	3.5	4.0	3.3
Other Long-Stay¹	281	265	199	217	201	283
Beds (in thousands)	40	28	22	23	24	33
Beds per 1,000 Enrollees	1.8	1.1	0.8	0.8	0.9	1.2

¹ Beginning October 1, 1983 a number of short-stay pediatric, rehabilitation, and alcohol/drug hospitals were re-assigned non-short-stay provider numbers and are included in this category for 1985, and 1986.

NOTE: Counts are as of July 1.

Table 5

STRONG GROWTH IN MOST PROVIDERS OF ALTERNATIVE CARE

	1975	1980	1985	1986	1987	1988
Skilled Nursing Facilities	5,295	5,052	6,451	6,897	7,379	7,507 ¹
Beds in Thousands	287	436	N/A	449	450	456
Home Health Agencies	2,242	2,924	5,679	5,978	5,688	5,688
Independent Laboratories	3,048	3,447	3,980	4,138	4,571	4,571
ESRD Facilities	—	999	1,394	1,463	1,753	1,755
Outpatient Physical Therapy	117	419	854	907	1,043	1,044
Portable X-Ray	132	216	308	347	409	409
Rural Health Clinics	—	391	428	432	449	450
Comprehensive Outpatient						
Rehabilitation Facilities	—	—	72	96	46	146
Ambulatory Surgical Centers	—	—	336	574	950	950
Hospice	—	—	164	268	522	522

¹ SNF facility and bed counts are as of January 1; all other counts are as of July 1.

NOTE: N/A is Not Available; — is Not Applicable.

Chapter I

The Medicare Population and Benefits

Introduction

Medicare enrollment increased in FY 1988 from 32.4 million to 33 million, and benefit outlays rose 7.3 percent from \$79.7 billion to \$85.5 billion. One out of every eight Americans had some Medicare coverage during the fiscal year, which means that the Medicare program covered about 13.1 percent of the United States resident population of 245.8 million.

Medicare Beneficiaries

Approximately 569,000 individuals were added to the Medicare rolls during the year. Some 498,000 of the new enrollees were 65 years of age or older, bringing to 29.8 million the number of aged beneficiaries, and 71,000 were younger disabled persons, increasing the number of disabled beneficiaries to 3.1 million. Included among the disabled were 53,000 with end-stage renal disease who must meet eligibility requirements different than those for other disabled beneficiaries.

Of the 33 million beneficiaries, 32.3 million were residents of one of the 50 States or the District of Columbia, 414,279 resided in Puerto Rico, 6,972 in the Virgin Islands, 1,223 in Guam, and 290 in American Samoa, the Northern Mariana Islands, and other outlying areas. Another 260,000 resided in foreign countries.

Fully 95.2 percent of the Medicare population in the 50 states and the District of Columbia, 64.8 percent of the beneficiaries in U.S. commonwealths and territories, and 17.1 percent of the beneficiaries in foreign countries, were enrolled in both Medicare Part A and Part B.

Women accounted for 57.8 percent of the total Medicare population, 59.9 percent of the beneficiaries 65 years of age and older, and

36.8 percent of the disabled enrollees. The percentage of disabled men, while down slightly in FY 1988 to 63.3, has remained relatively constant since FY 1980 as has the percentage of aged who are men. Minorities represent a growing proportion of the Medicare population. In FY 1988, 3.5 million Medicare enrollees were other than white. This represented 11 percent of the Medicare population, a rise of 0.3 of a percentage point over FY 1987 and an increase of 1.1 percentage points over FY 1980 when 9.9 percent of beneficiaries were non-white. While non-whites made up only 11 percent of aged beneficiaries, 20.5 percent of the disabled beneficiaries were other than white, an increase of nearly 1 percentage point over the figure for the previous fiscal year.

A significant demographic trend that has and will continue to affect Medicare is the increasing median age of beneficiaries. In FY 1973, 1.699 million beneficiaries, or 7.8 percent of the elderly population, were 85 and older. In FY 1988, 3.1 million, or 10.4 percent of the aged population, were in the 85-and-over category. The aging of the Medicare population is an important economic factor as older beneficiaries generally require greater and more intense health care services than do younger beneficiaries.

Benefit Expenditures

Medicare benefit payments for FY 1988 totaled more than \$85.5 billion, or 7.3 percent more than for the previous fiscal year. In FY 1988, the medical component of the Consumer Price Index (CPI) increased by 6.3 percent while the CPI for all items, less medical care, increased 4 percent. Benefits paid under Medicare Hospital Insurance (Part A) increased by 4.1 percent (Table 6), while those paid under

Medicare Supplementary Medical Insurance (Part B) increased by 12.5 percent (Table 7). Benefit payments for FY 1988 were broken down as follows:

- Hospital Insurance (Part A)--\$51.9 billion
- Supplementary Medical Insurance (Part B)--\$33.7 billion

Part A spending was divided among its components as shown in Table 6.

Table 6

Benefit	FY 1987	FY 1988	% Change
Dollars in Millions			
Inpatient Hospital	\$46,830	\$48,770	4.1
Skilled Nursing Facility	616	712	15.6
Home Health	2,263	2,239	-1.1
Hospice	68	137	101.5

Of all purchases, hospital care, at \$48.8 billion, accounted for the largest portion of Medicare spending during the fiscal year. Fifty-seven percent of Medicare's total benefit expenditures and 94 percent of Part A outlays went for inpatient hospitalization. Medicare beneficiaries are entitled to 90 days of inpatient hospital care in each benefit period. They also have 60 "lifetime reserve days" which can be used whenever more than 90 days of hospitalization are required. Once used, lifetime reserve days are not renewable.

Medicare paid \$712 million for skilled nursing facility (SNF) services in FY 1988, or about 15.6 percent more than in the last fiscal year. The cost of SNF services accounted for about 1.4 percent of Part A outlays during the year. Medicare beneficiaries are entitled to 100 days of covered care during a benefit period in a skilled nursing facility after an inpatient hospital stay of at least three consecutive days, provided certain other conditions are met.

The \$2.2 billion spent on home health services during the fiscal year was 1.1 percent lower than in FY 1987 and accounted for about 4 percent of Part A spending. Part A covers home health visits with no prior hospitalization

requirement. The care needed must include part-time or intermittent skilled nursing care, physical therapy or speech therapy, and the patient must be homebound.

For the second consecutive year, the greatest percentage increase in any single category of Medicare spending during FY 1988 was for hospice care, which increased 101.5 percent, from \$68 million in FY 1987 to \$137 million.

The rise was primarily due to the growing popularity of hospice care, which accounted for \$4 million in Medicare spending when it was introduced as a benefit in 1984. Part A of Medicare pays for hospice care when a physician certifies that a patient is terminally ill; the patient chooses hospice care instead of standard Medicare benefits for the terminal illness; and care is provided by a hospice program approved by Medicare.

Supplementary Medical Insurance

Part B, which, at \$33.7 billion, was 12.5 percent higher than in FY 1987, was broken down as shown in Table 7.

The \$24.2 billion spent for physician services was 11 percent more than the FY 1987 outlay and represented nearly 72 percent of Part B spending for the fiscal year. Part B generally pays 80 percent of Medicare-approved charges for medical services after the beneficiary pays the first \$75 in approved charges each calendar year. Medicare spending for outpatient services increased from \$5.8 billion in FY 1987 to \$6.5 billion. Outpatient services provided by hospitals are covered under Part B.

Table 7

Benefit	FY 1987	FY 1988	% Change
Dollars in Millions			
Physicians	\$21,925	\$24,243	10.6
Outpatient Services	5,780	6,452	11.6
Group Practice	1,336	1,952	46.1
Independent Laboratory	847	975	15.1
Home Health	49	60	22.4

The 46 percent increase in outlays for group practice plans, rising from \$1.3 billion to \$1.9 billion, represented the highest percentage increase of any component of Part B and reflects the increased number of Medicare beneficiaries enrolled in prepayment plans, such as health maintenance organizations (HMOs) and competitive medical plans (CMPs). The 22.4 percent increase in home health benefit outlays was the second highest percentage increase of the Part B components, rising from \$49 million to \$60 million. However, this represented a relatively small share of total Part B spending because most home health care is covered by Medicare Part A. Also climbing significantly was the percentage of Part B spending for independent laboratory services, jumping 15.1 percent from \$847 million in FY 1987 to \$975 million in FY 1988.

Providers

The number of participating hospitals rose slightly in FY 1988 from 6,677 to 6,687. The number of short-stay hospitals slipped from 5,872 to 5,800 and other long-stay hospitals increased from 278 to 283. At the same time, the number of psychiatric hospitals remained unchanged at 604.

Inpatient hospital admissions increased an estimated 0.1 percent for the fiscal year to 10.4 million following a fall-off of about 2 percent in FY 1987. Increases also were registered in the average number of discharges and days of care per 1,000 Medicare enrollees. There were 339 discharges per 1,000 beneficiaries in FY 1988 compared with 330 discharges per 1,000

beneficiaries for the previous 12-month period. Moreover, the 3,029 days of care per 1,000 enrollees in FY 1988 was 4.9 percent higher than in FY 1987. The average length of a hospital stay was 8.9 days, the same as in FY 1987.

During the fiscal year the number of SNFs rose from 7,379 to 7,507, and the number of SNF beds increased by about 26,000 to 456,000. The number of home health agencies remained at 5,688, the same as in FY 1987.

Other providers participating in Medicare during the fiscal year included 4,571 independent laboratories, 1,755 end-stage renal disease (ESRD) facilities, 146 comprehensive outpatient rehabilitation facilities, 950 ambulatory surgical centers, and 522 hospices.

Program Funding

Under the Social Security Act, the Federal Hospital Insurance (Part A) and the Federal Supplementary Medical Insurance (Part B) Trust Funds are administered by two boards of trustees, each with the same five members. Three members serve in an *ex officio* capacity: The Secretary of Treasury, who by law serves as managing trustee of both funds, the Secretary of Labor, and the Secretary of Health and Human Services. Two public members are nominated by the President for 4-year terms subject to confirmation by the Senate. The Administrator of HCFA serves as secretary of both boards.

The primary source of Part A financing (91 percent) is derived from payroll taxes paid by workers and their employers and by

self-employed individuals. The remaining 9 percent comes from Federal general revenues for certain insured individuals who attained age 65 before 1975, premium payments for voluntarily enrolled individuals, transfers from the Railroad Retirement Board, military service credits, and interest on accumulated funds.

Part B is financed by three sources: (1) premium payments from enrollees, (2) contributions from general revenues, *and* (3) interest on trust fund reserves.

The Part B premium under the Tax Equity and Fiscal Responsibility Act and the Deficit

Reduction Act is set at 25 percent of program costs. In FY 1988 beneficiary premiums covered 25 percent, and government contributions 73 percent, of the cost of Part B. Interest on trust fund reserves covered the other 2 percent.

More detailed information about the status of the trust funds, showing income, disbursement and future projections, is contained in the annual reports to the Congress by the trustees of the respective funds.

Chapter II

Ensuring Quality of Care

Introduction

One of the priorities of HCFA in FY 1988 was to develop, demonstrate, and evaluate methods for measuring the quality of care afforded Medicare patients by certified providers. The intent was to promote and ensure effective and efficient delivery of all necessary medical services to beneficiaries. As in past years, PROs were integral to the quality-assurance effort.

PROs are charged by law to assure that services rendered to Medicare beneficiaries are medically necessary, are provided in the most appropriate setting (e.g., acute care hospital versus skilled nursing facility or a lesser level of care), and meet professionally recognized standards of quality. The PRO program was created by the Peer Review Improvement Act of 1982, Title I, Subtitle C of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

PRO reviewers (usually nurses) use criteria screens for review which are developed by local physicians to approve cases which clearly meet acceptable standards and refer questionable cases to a physician affiliated with the PRO for further review. If, after review, the PRO physician-reviewer determines there is a quality problem, the PRO will initiate corrective action. If the PRO physician-reviewer determines the care was not medically necessary or that it should have been provided in another setting, the PRO will issue a payment denial. Only a PRO physician-reviewer may deny a case or confirm that there is a quality problem, but only after the attending physician and provider have been given an opportunity to discuss the case with the PRO.

Quality Review Process

In the second PRO contract cycle (1986-1988), greater emphasis was placed on the quality review process. This resulted in a more structured approach, thus ensuring commitment of a higher percentage of PRO resources to quality-of-care reviews. In stressing quality review, the following actions were taken:

- Generic screens were provided as a tool to assist in identifying potential quality problems and were required to be applied to each case undergoing retrospective review.
- Each case selected by the PRO for retrospective review was required to be examined for the appropriateness of the discharge.
- The scope of the PRO objectives were broadened to better address quality issues by focusing on problems identified through generic screen review and HCFA-identified adverse outcomes, such as mortality or premature discharge.

Areas of Review

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 1985) authorized PROs to review services provided by HMOs and CMPs with Medicare risk contracts under section 1876 of the Social Security Act. The Omnibus Budget Reconciliation Act of 1986 (OBRA 1986) mandated PRO review of inpatient and outpatient services rendered by entities with section 1876 contracts. This included the authority to determine whether appropriate services were provided and, if so, whether they were accessible, properly utilized, of adequate quality, and provided in the appropriate setting. The review for risk-based HMO/CMP services was effective for services rendered on and after April 1, 1987, and was implemented beginning June 1987.

Beginning in August 1987, PROs also were required under OBRA 1986 to conduct an appropriate review of all written complaints from beneficiaries about the quality of professional medical services provided by HHAs, SNFs, and hospitals. PROs are required to notify the beneficiary of the final disposition of the complaint.

Another provision of OBRA 1986 requires PROs to review a sample of cases in which beneficiaries are readmitted to hospitals within 31 days of a previous discharge. It is intended to help determine whether patients were prematurely discharged from the first admission. PROs also review, on a sample basis, SNF, HHA, and hospital outpatient care provided between the two hospital admissions. Reviews in this area were implemented by all PROs as of April 1, 1989.

Findings During FY 1988

Data compiled for the period October 1987 to September 1988 indicates that PROs identified the following potential quality-of-care problems:

- Physicians identified with possible quality-of-care problems totaled 24,969.
- Hospitals identified with possible quality-of-care problems totaled 804.
- Discharges failing one or more HCFA-provided generic quality screens totaled 737,218.
- Physicians (266) and providers (53) with potential substantial or gross and flagrant violations totaled 319.
- Premature discharge of patient and/or readmission of a patient for care that should have been provided during the first admission totaled 9,465.
- Inappropriate transfers from a PPS unit to a PPS-exempt unit in the same hospital or a PPS-exempt unit to a PPS unit in the same hospital totaled 359.

Report on the Long-Term Care Survey Process

Oversight of the care provided to Medicare and Medicaid beneficiaries residing in SNFs and intermediate care facilities (ICFs) is the responsibility of HCFA. This oversight is provided through the conduct of a survey at least once a year of each SNF and ICF participating in either the Medicare or Medicaid program, or both.

Section 1864 of the Social Security Act requires the Secretary to enter into agreements with States to survey nursing facilities to determine whether they are in compliance with Medicare participation requirements as set forth in section 1861(j) of the Act. Section 1902(a)(33)(B) of the Act requires a State's Medicaid agency to contract with the State survey agency used by Medicare (if they are responsible for licensing health facilities), to determine whether nursing facilities meet the requirements for participation in the Medicaid program. SNF requirements appear in section 1902(a)(28) and ICF requirements are described in section 1905(c) and (d) of the Act.

The survey requirements and procedures for Medicare-participating facilities are described in subchapter B, Part 405 of title 42 of the Code of Federal Regulations (CFR), while subchapter C, part 442 provides that information for Medicaid-participating facilities.

Over the last several years HCFA, with the advice and assistance of many professional and consumer groups, the long-term care industry, and other interested parties, has developed a new long-term care survey process. It is oriented toward evaluating actual resident care rather than focusing on the administrative and structural abilities of a facility, which only indicates a facility's capacity to deliver care.

FY 1988 Activity

HCFA continued to refine the long-term care survey process and the instructional mate-

rial and personnel training integral to its proper implementation. Related activities undertaken during the fiscal year included:

- Publication on June 17 of a final rule detailing procedural and care guidelines as well as all required forms used in the long-term care survey process.
- Training a cross section of Federal and State surveyors in the revised procedural and care guidelines and sampling procedures.

Medicare Hospital Mortality Information

HCFA released to the public the first annual Medicare Hospital Mortality Information Report (1986). This seven-volume report, prepared by HCFA using information extracted from the Medicare Provider Analysis and Review (MEDPAR) File, detailed the Calendar Year 1986 mortality rates and the expected mortality ranges for all Medicare patients with

an admission to a Medicare-certified hospital in the United States during that year. The rates and ranges were reported both for all causes and for 16 diagnostic categories.

The expected ranges were developed using a formula which considered a number of factors unique to each patient and, thus, they reflect each hospital's individual caseload rather than a national average. Prior to releasing the information, each hospital was provided with a copy of the data and was afforded the opportunity to comment on it for the record. Approximately one-half of the hospitals submitted comments and they were included in the publication. The report proved useful to health care professionals in examining the quality of care in their hospitals and to the general public who were able to use this information as a basis for more informed discussions with their own health care providers.

Encouraging Competition and Choice

Introduction

Following the significant increase in the number of Medicare beneficiaries enrolled in prepaid health plans in FY 1986 and FY 1987, HCFA continued its efforts to provide beneficiaries with an alternative to traditional fee-for-service Medicare through contracts with health maintenance organizations (HMOs) and competitive medical plans (CMPs). The expansion of Medicare enrollment in such plans was facilitated by the provisions of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which authorized HCFA to contract with HMOs and CMPs on a "risk" basis. Under a risk agreement, HCFA pays HMOs and CMPs a prospectively determined capitation rate without retrospective adjustments for actual costs incurred. Previously, HMOs were paid on a reasonable cost basis or they shared the risk with HCFA, using a payment method that required retrospective adjustments for incurred costs. The TEFRA risk-contracting program was implemented in 1985 and forms the basis for HCFA's "private health plan option" initiative.

A prepaid health plan may generally be described as an organization that provides its members comprehensive health services in return for a predetermined, fixed monthly payment, or premium, for each enrolled member. The premiums for commercially enrolled members of HMOs are often paid in whole or in part by an employer group which contracts with the organization for the provision of health care services to the members of the employer group. Under a Medicare risk contract, HCFA similarly makes a monthly payment to the organization for each Medicare beneficiary who enrolls in the HMO. The Medicare payment rate is determined annually and varies depending on the geographic area served by the HMO

and certain particular characteristics of the enrolled beneficiaries (e.g., age, disability status).

In addition to the monthly capitation payments that HCFA makes on behalf of Medicare beneficiaries, individual Medicare enrollees of an HMO must generally pay a monthly premium to the organization, as well as nominal copayments for particular services received. These premiums and copayments cover the portion of physician and provider charges that is not covered by Medicare (e.g., 20 percent coinsurance for Part B services) and services that are not covered by Medicare. The Medicare statute sets an upper limit on the amounts an HMO may charge a beneficiary, based on the average expenses of beneficiaries across the country for Medicare-covered services and the amounts the HMO would charge its commercial enrollees for Medicare-covered services.

Prepaid health care organizations reduce costs by emphasizing preventive care and health education, and by managing the care provided to enrollees. In a managed care setting, there may be better access to health care, medical conditions may be treated at an early stage in their development through less expensive means than would otherwise be required, and the provision of duplicative and other unnecessary services may be eliminated.

HCFA's requirements emphasizing continuity of care, internal quality assurance programs, and external quality review by PROs also encourage high quality health care in the managed care setting. Enrollment in prepaid health care organizations is attractive to many Medicare beneficiaries because payment of a monthly premium for all of their health care needs facilitates budgeting of health care expenses and limits their out-of-pocket costs; there are no claims forms to worry about; and they often receive, at little or no extra cost,

additional health care benefits that are not otherwise covered under the Medicare program.

Medicare Contracts with HMOs/CMPs

FY 1988 was an important year for HCFA in its effort to increase choice for Medicare beneficiaries through expansion of the private health plan option. The number of Medicare beneficiaries enrolled in HMOs and CMPs contracting on a risk basis exceeded the 1 million mark. By the end of FY 1988, 1.1 million beneficiaries were enrolled in these organizations, and there were a record 161 Medicare risk contracts with prepaid health plans across the country (Table 8). Expansion of the private health plan option became an established, integral part of the HCFA mission.

Implementation of Medicare Catastrophic Provisions in Prepaid Health Care Organizations

Following enactment of the Medicare Catastrophic Coverage Act of 1988, HCFA adopted an aggressive approach to advising prepaid health care organizations and Medicare beneficiaries who are enrolled in these organi-

zations about the expanded coverage. The basic message was that Medicare beneficiaries who are enrolled in prepaid health care organizations would receive special protection against catastrophic health care costs through their HMO/CMP. Toward the end of FY 1988, HCFA mailed an individual notice (in both English and Spanish) to every Medicare beneficiary enrolled in a prepaid health care organization. This notice described the new benefits that would be phased in beginning in January 1989; discussed the advantages of remaining in an HMO/CMP and receiving the catastrophic benefits through the plan; and described how to get additional information about the catastrophic benefits.

HCFA also provided information to each HMO/CMP describing the new requirements of the Medicare Catastrophic Coverage Act, including the provisions that applied specifically to prepaid health care organizations. Implementation of these provisions required contract modifications, revision of marketing materials, and, prior to 1990, new systems to account for enrollees' out-of-pocket expenses.

Medicare payments to risk-contracting HMOs/CMPs were announced in September 1988, reflecting an average \$7 monthly increase

Table 8

MEDICARE CONTRACTS WITH HMOS/CMPs — FY 1988

Type of Contract	Contracts		Enrollees		Payment FY 1988
	10/1/87	9/30/88	10/1/87	9/30/88	
TEFRA Risk	158	153 ¹	981,068	1,040,966	\$3,048.0
Pre-TEFRA Risk	4	4	52,523	55,243	108.1
Demonstrations (Risk)	7	4	29,323	15,949	78.2
Cost	43	32 ²	119,171	128,187	111.1
Health Care Prepayment Plans (Cost)	33	34 ³	613,873	542,245	482.2
Total	245	227	1,795,958	1,782,590	\$3,827.6

Note: Dollars in Millions.

¹ Includes 21 contracts which were signed, but under which no beneficiaries were enrolled and no payments were made.

² Includes 9 contracts for reasonable cost-reimbursement with organizations which subsequently signed TEFRA risk contracts but still have beneficiaries who are enrolled under the cost plan.

³ Includes enrollment of 13 health care prepayment plans (HCPPs) that subsequently signed risk contracts.

per member to account for expanded Medicare benefits. Organizations were required to reduce beneficiary cost-sharing amounts to reflect the reduction in beneficiary liability amounts under the catastrophic coverage act for hospital and skilled nursing facility care.

HMO/CMP Oversight Activities

HCFA fully implemented a comprehensive monitoring program during the fiscal year, with staffs in the agency's central office and 10 regional offices employing the program on-site at 60 HMOs/CMPs to evaluate their compliance with statutory and contractual requirements.

During the same period, HCFA's regional offices began using the Beneficiary Inquiry Tracking System (BITS), which is designed to assure that complaints received from Medicare beneficiaries about HMOs/CMPs are monitored and resolved on a timely basis. A HCFA-designed disenrollment survey form to obtain information from Medicare beneficiaries disenrolling from Medicare risk contacting HMOs/CMPs was also cleared by the Office of Management and Budget. The survey form was pre-tested, and final plans were developed for the implementation of the full survey. A sample of 17,000 beneficiaries was asked about their reasons for disenrolling from risk-contracting HMOs/CMPs. The survey was designed to ascertain whether Medicare beneficiaries disenrolled from HMOs/CMPs due to their perceived need for health care. It will also help HCFA to determine the extent to which prepaid health plans may be encouraging beneficiaries who have greater health care needs than other enrollees to disenroll from the plan. The survey results will be used by HCFA to determine whether routine monitoring of disenrollments is needed.

Another advancement during the reporting period was the completion of the design for the Plan Information Control System (PICS), which combines a number of databases containing information about HMOs and CMPs. PICS

was designed to automate certain current HMO/CMP data collection activities and link new databases with existing databases to create an integrated information system. PICS will enhance HCFA's ability to determine if HMOs/CMPs are complying with the qualification and contract requirements by providing on-line access to all data relating to each organization. The first phase of PICS development began late in FY 1988, with full implementation scheduled for FY 1989.

Finlay Medical Centers Termination

On March 1, 1985, HCFA entered into a demonstration contract with Finlay Medical Centers, a prepaid health care organization in Miami, Florida. The purpose of the demonstration was to test the feasibility of paying a risk-contracting entity at a rate equal to 85 percent of the adjusted average per capita cost (AAPCC) of providing Medicare-covered services in fee-for-service settings. Normally, HCFA pays risk-contracting HMOs and CMPS 95 percent of the AAPCC for the area served by the organization.

On February 16, 1988, HCFA notified Finlay that the demonstration would be terminated on May 31, 1988, because of performance problems and inadequate protection against the risk of insolvency. The health plan's provider network was rapidly deteriorating, largely because of Finlay's failure to pay its providers on a timely basis. In late March 1988, HCFA declared Finlay in default of its Medicare contract. HCFA notified beneficiaries who were enrolled in Finlay that they were to be disenrolled effective April 1, and HCFA ceased making payments to Finlay as of that date. The Florida State Department of Insurance subsequently initiated insolvency proceedings in State court, which led to the corporate dissolution of Finlay Medical Centers. The following HCFA actions provided Medicare beneficiaries a smooth transition from enrollment in Finlay:

- Creation of a HCFA task force in Miami to ensure beneficiary access to health care and to answer beneficiary questions.
- Mailings in Spanish and English to Finlay's Medicare enrollees assuring them that their Medicare coverage remained intact and apprising them of their options.
- Establishment of a special enrollment process so that those Finlay enrollees who elected to join other prepaid health plans could do so without any interruption in their HMO coverage.
- Arrangements for beneficiaries to purchase Medicare supplemental insurance without waiting periods or exclusions for any pre-existing health conditions.

Improvements in the Reconsideration Process

When Medicare members of HMOs/CMPs are dissatisfied with any decision of the organization to deny a service or payment for a service, they may file a request with the HMO/CMP to reconsider the initial determination. Unless the HMO/CMP's reconsidered determination is wholly favorable to the beneficiary, the matter is forwarded to HCFA for review.

Until 1987, the HMO/CMP reconsideration function was performed by the same HCFA office that provided oversight of the fiscal intermediary and carrier appeal process. HCFA received only 50 reconsideration cases for review during 1985 and 1986; in 1987, 200 cases were received. HCFA decided in 1987 that the reconsideration process could be handled more efficiently by a private contractor, and steps were taken in FY 1988 to procure and award such a contract on a competitive basis. Prior to the contract award to Network Design Group, effective January 1, 1989, HCFA staff processed more than 1,300 reconsideration cases. As a result of these reviews, HCFA obtained important information about problems being experienced by beneficiaries as well as HMOs. Administrative and regulatory initiatives to improve the Medicare HMO/CMP

program and eliminate these problem areas have since been taken.

Improved Efficiency of Enrollment and Disenrollment Process

The Group Health Plan (GHP) System, which HCFA uses to process prepaid health plan enrollment and disenrollment data, was designed more than 15 years ago to serve a small number of organizations. The capacity of the GHP System has been severely taxed as more organizations participate in Medicare and an increasing number of Medicare beneficiaries enroll in prepaid health plans. To meet this increased demand, HCFA initiated the GHP Redesign Project during the latter part of FY 1987 as a project that would be implemented over the following 4 fiscal years. The new system will maintain more information, make better use of current technology, and should ultimately result in more accurate and timely payments to prepaid health plans.

In the first stage of the GHP redesign, HCFA obtained and made available to staff in the central and regional offices direct access to the Health Insurance/Supplementary Medical Insurance (HI/SMI) Beneficiary On-Line Inquiry System. This eliminated the need for manual processing of HCFA requests for Medicare beneficiary health insurance printouts (providing current HMO status) from the HI master file. These printouts are a key tool that HCFA staff needs to resolve beneficiary enrollment and disenrollment problems.

In the manual process, it could take as long as 4 to 5 weeks for a regional office to obtain a health insurance printout; now the information can be obtained within minutes. This immediate access permits HCFA to quickly resolve any Medicare beneficiary enrollment and disenrollment problems and provide better service to the Medicare beneficiary.

HCFA also established the ability to correct a beneficiary's HMO information on the Medicare master beneficiary record. The changes are processed electronically and displayed on

the beneficiary's master record within a few days after being keyed into the system. This system's capability has greatly enhanced HCFA's ability to resolve beneficiary-HMO problem cases that would otherwise result in delayed payments of bills properly submitted to Medicare carriers and intermediaries after a Medicare beneficiary has disenrolled from an HMO.

HCFA also made significant strides in strengthening the HMO/CMP disenrollment process that is administered through the field offices of the Social Security Administration (SSA). The Program Operations Manual System instructions that SSA staff use were updated and clarified, and the HMO/CMP disenrollment form (HCFA-566) was revised to reduce the likelihood of errors. This activity improved the ability of SSA personnel to serve Medicare beneficiaries enrolled in prepaid health plans.

Medicare HMO/CMP Payment System Improved

In November 1987, HCFA implemented a new automated plan payment system (APPS). The new system includes advanced systems security features, and provides HCFA with the ability to make payments to HMOs and CMPs based on a verified, actual enrollment count rather than an estimate of enrollment. This virtually eliminated HCFA's need to do monthly payment reconciliations for prepaid health plans. The APPS was used during the fiscal year to make over \$4 billion in payments to prepaid health plans.

Managed Care Demonstration Activities

During FY 1988, HCFA planned, developed and implemented a number of demonstrations related to managed care, including the following:

- **Diagnostic Cost Groups (DCG)**

This pilot demonstration was designed to test an alternative payment methodology that

expands upon the AAPCC methodology currently used to pay risk-contracting HMOs and CMPs. The DCG methodology, which was developed by researchers at Boston University, refines the AAPCC by making adjustments based on the HMO enrollees' hospital utilization during a prior 12-month period. The DCG approach is predicated on the theory that most individuals who have been hospitalized during a given year can be expected to incur higher health care costs in the following year. During FY 1988, HCFA began the initial phase of the pilot demonstration, during which any problems relating to the exchange of hospitalization data and payment information between the HMOs and HCFA will be identified.

- **Medicare Insured Groups**

Work continued in FY 1988 on planning a demonstration program to expand Medicare risk-contracting to employers and unions that provide health benefits to their retirees. Under the Medicare Insured Group (MIG) demonstration, HCFA would pay the employer or trade union a monthly rate (based on 95 percent of the group's estimated Medicare costs) for each Medicare beneficiary enrolled in the managed care plan sponsored by the MIG. The sponsoring employer or union would then assume responsibility for providing or arranging all Medicare-covered benefits to the beneficiaries in the group. HCFA has developed additional technical assistance documents that supplement those produced in FY 1987 for organizations interested in the MIG demonstration project.

In FY 1988, HCFA executed cooperative agreements with two organizations for the development of MIGs: Amalgamated Life Insurance Company (ALICO) and Chrysler Corporation/United Auto Workers. During the year, ALICO progressed to the point of negotiating with several hospitals in Philadelphia to become part of ALICO's MIG health care

delivery system. Chrysler Corporation/United Auto Workers performed an in-depth feasibility study by analyzing various data sets to identify the past health care experience of their retirees and exploring other aspects of the proposed MIG project. HCFA met with a number of other employers, trade union, and insurers interested in learning more about the MIG projects.

Physician Preferred Provider Organizations

Plans for a preferred provider organization (PPO) demonstration were developed by HCFA during the fiscal year to assess the cost effectiveness of PPO arrangements in controlling the volume of Medicare services performed or ordered by physicians. Under the demonstra-

tion, Medicare beneficiaries may elect to join a PPO and receive enhanced Part B benefits when using the PPO physicians. Institutional services are not included under the demonstration. HCFA awarded cooperative agreements to the following five PPOs in FY 1988 to participate in the demonstration project: CappCare (California); Blue Cross and Blue Shield of Arizona; Family Health Plan (Minnesota); Health Link (Missouri); and CareMark (Oregon). Extensive discussions between HCFA and the PPOs, as well as affected Medicare carriers, fiscal intermediaries and PROs, continued through the fiscal year in order to plan for the implementation of the demonstration. At least three of the sites are expected to become operational in early 1990. Mathematica Policy Research will conduct the evaluation of the project.

Chapter IV

Efficient Operation of Medicare

Introduction

Medicare contractors fulfill the Federal government's responsibility of paying Medicare beneficiaries and providers of service in a timely, accurate, and fiscally responsible manner. Fiscal intermediaries pay providers of services under Medicare Hospital Insurance (Part A), primarily for hospital inpatient activities. Their responsibilities encompass making and accounting for Medicare benefit payments, auditing the financial records of providers, making final settlement of cost reports, recovering any Medicare overpayment, and safeguarding the Medicare trust funds against payment for services that are not medically necessary. Carriers adjudicate claims and make payments to beneficiaries and providers of service under Medicare Supplementary Medical Insurance (Part B), primarily for physician services. Their responsibilities include receiving and accounting for Medicare benefit claims, accounting for payments made directly to and/or on behalf of eligible Medicare beneficiaries, determining allowable reasonable charges for medically necessary covered services, and computing and recovering overpayment in cases of erroneous payment. They also implement the participating physician program, establish methods to identify utilization patterns which deviate from medically accepted norms and report such deviations to the appropriate professional groups.

In FY 1988, HCFA had contracts with 89 intermediaries and carriers, including two experimental, fixed-price contracts. As part of its contract enforcement activities, HCFA monitors the contractors' expenditures, tracks savings realized from payment safeguard activities and productivity investments, and reviews contractor performance in paying claims, serving Medicare beneficiaries, and

assuring the fiscal integrity of the Medicare trust funds.

Distribution of Medicare Claims

Intermediaries received 72 million claims in FY 1988, a 7.2 percent increase above the FY 1987 level. Outpatient services accounted for 66.1 percent and inpatient hospital services for 15.9 percent of the claims. Home health agency and skilled nursing facility claims accounted for 7.1 percent and 1.1 percent, respectively. The remaining 9.9 percent were claims submitted for ancillary and other miscellaneous services payable under Part B. The unit cost to process these claims was \$1.57. Carriers received 378.3 million claims during the fiscal year, or 13.1 percent more than during FY 1987. During the same period, the percentage of claims submitted by physicians and medical suppliers who accepted assignment increased from 71.7 percent to 76.3 percent. The unit cost to process all claims filed with carriers was \$1.65.

Of the total claims submitted during the fiscal year, 52 million intermediary and approximately 129 million carrier claims were filed electronically. The cost of processing the electronic media claims (EMCs) was considerably less than what it would have cost to handle the same number of paper claims.

Claims Processing Timeliness

Congress established new policies in section 9311(b) and (c) of OBRA 86, which enacted sections 1816(c)(2) and 1842(c)(2) of the Social Security Act, for the timely payment of Medicare claims. Both Part A and Part B contractors were required as of the beginning of the fiscal year to pay at least 95 percent of all "clean" Medicare claims within 26 days. They were required to pay 95 percent of all claims

within 60 days and 99 percent of all claims within 90 days. Since April 1987, intermediaries and carriers failing to meet the claims processing timeliness (CPT) deadlines have been required to pay interest on clean claims not paid within 26 days. For Part A claims, eligible hospitals had periodic interim payments (PIP) discontinued as soon as CPT requirements were met by individual intermediaries for any three consecutive months, in accordance with section 9311(a)(3) of OBRA 86. This provision went into effect as of April 1987. In December 1987, Congress enacted as part of OBRA 87 a provision requiring that all Medicare claims received during the period of

July 1, 1988, through September 30, 1988, be held 10 days before being paid. For FY 1989, OBRA mandates that all claims received on or after October 1, 1988, be held 14 days before payment is permitted.

By the end of the fiscal year, Part A and Part B contractors had achieved considerable success in complying with the claims processing requirements. The requirement for paying at least 95 percent of all clean claims within 26 days was met by all but one intermediary and three carriers. (Two of the carriers were Prudential sites which subsequently withdrew from the Medicare program.) The 19-day requirement for paying physicians who signed agreements to participate in Medicare was met by 42 of the 48 Part B carriers. (Three of the six carriers were Prudential sites.) All Part A intermediaries met the 60-day payment requirement while the 90-day payment requirement was met by all but two intermediaries.

For Part B, all but one carrier met the 60-day payment requirement, and two marginally failed to meet the 90-day payment requirement.

At the close of FY 1988, an analysis of CPT data revealed that a number of contractors had experienced systems problems in implementing the payment requirements imposed by OBRA 1987. Through this analysis, HCFA identified several forms of corrective action for the contractors to implement to resolve these problems.

Denied Claims Review

Medicare claimants who disagree with the decisions on their claims have a right to appeal. After denial of a Part A claim, the claimant can request a reconsideration by the intermediary. If the claim is again denied, the claimant may request a hearing and subsequent review before an administrative law judge (ALJ) and the Appeals Council, respectively, within the Social Security Administration. During FY 1988 there were 61,689 reconsideration requests, a 30 percent decrease over the number of reconsiderations in FY 1987. Thirty-three percent of the reconsiderations resulted in adjustments favorable to the claimants.

For a denied Part B claim, a claimant has the right to a carrier review, a carrier hearing, and, for claims for services on or after January 1, 1987, a hearing before an ALJ, subject to subsequent review by the Appeals Council. In FY 1988, carriers processed 5.7 million review requests, an increase of 5 percent over the FY 1987 level. Of those reviewed, 55 percent resulted in reversals. Carrier hearings during the fiscal year numbered 67,632, an increase of 40 percent over the FY 1987 level. Forty-three percent of the hearings resulted in reversals.

Common Working File

As part of a continuing effort to simplify, speed, and improve the processing of claims, HCFA maintained common working file (CWF) sites during the fiscal year at Maryland Blue Shield and Texas Blue Shield. This is the initial phase of a plan to create a hierarchically distributed claims processing system based on a series of localized data bases (host sites), each serving a network of contractors (satellite sites) within defined geographical areas. Under the plan, host sites will maintain beneficiary-specific files containing complete entitlement, utilization, and history data. All Part A and Part B claims will be processed against this single file. It is expected that contractor operations will be simplified through the elimination

or reduction of processes such as query/reply, admissions notices, batch clearances, and payment records. Enhanced protection for the Medicare trust funds would be achieved, in part, through prepayment Part A and B history reviews, expansion of the base to check for duplicate claims, immediate Medicare secondary payer status updates, and reductions in adjustment processing. This translates into fewer overpayment recovery actions.

In a related action, HCFA successfully tested a system at Arizona Blue Cross for the remote “teleprocessing” of data between a CWF host site and satellite sites. A determination will be made in early FY 1989 as to whether the system will be implemented nationally. A fully automated telecommunications system linking selected fiscal intermediaries to HCFA’s central office was also experimented with during the year. This network could support automated claims data interchange and CWF implementations in the future. A major interest of HCFA is to maximize the use of standard claims processing systems to reduce administrative costs and more readily implement legislative requirements. Four Part A standard processing systems and two Part B standard systems were operational in FY 1988. HCFA’s pilot program with Travelers Insurance Company to develop a new standard system was successful and by the end of the fiscal year was available for use by other contractors.

Payment Safeguards

In addition to processing payment claims for providers of service and Medicare beneficiaries, contractors perform other vital functions. These include conducting medical reviews of claims to ascertain whether services are medically necessary and constitute an appropriate level of care, auditing Medicare cost reports of providers, and assuring that under certain circumstances Medicare is the secondary payer if the health care services rendered a Medicare beneficiary are covered by another insurer.

These payment safeguards accounted for savings of \$3.2 billion in FY 1988 as follows:

Medical Review/	
Utilization Review	\$ 0.9 Billion
Medicare Secondary Payer	\$ 1.4 Billion
Audit	\$ 0.9 Billion

Carrier Medical Review

Ensuring that Medicare payment is made only for reasonable and necessary physician services is the responsibility of the Medicare carriers. Carriers execute this responsibility through a blend of prepayment reviews of individual services and postpayment review of utilization patterns of physician and supplier services. Carriers perform indepth prepayment reviews on 15 percent of claims using a blend of discretionary carrier screens and 18 screens required by HCFA. Screens are mandated for routine foot care, mycotic nails, new patient office visits, holter and real-time monitoring, chiropractic services, concurrent care, hospital visits, comprehensive office visits, and skilled nursing facility visits. They are also required for replacement of post-cataract external prosthetic contact lenses, comprehensive initial hospital visits, intermediate hospital visits, consultations, A-mode scans, seatlift chairs, transcutaneous electrical nerve stimulators (TENS), and physician inpatient dialysis services.

The medical policy that serves as the basis for the review of screened claims is developed by the carrier medical director, a physician, in consultation with the respective State medical society, and other specialty organizations. The policy, which includes information on appropriate documentation, is communicated to physicians through newsletters prior to using it in the review of claims. Medical reviews have been cost-effective, with FY 1988 program savings of approximately \$10 for each administrative dollar expended.

Additionally, carriers perform comprehensive postpayment reviews of providers whose

practice patterns suggest excessive utilization. HCFA will implement a complete revision of the postpayment process in FY 1989. The new process initially will enable carriers to better target providers for comprehensive review. The comprehensive reviews will look at a 6-month snapshot of services, including claims and supporting medical records. Pilot testing of the new procedures in FY 1988 at seven carriers resulted in dramatic increases in the identification of overpayments and the number of cases referred to HHS's Office of Inspector General for fraud or abuse investigations.

The need for increased oversight is pointed up by the rapid rise in health care costs. Medicare physician payments increased nearly four times as much as overall Federal domestic spending between FY 1975 and FY 1988. These payments are projected to triple over the next 10 years even without any expansion of the Medicare program. About half of the increase in Medicare's physician spending per aged enrollee over the past 10 years is attributable to a greater and more intense use of new health care services and technology. Price increases and population accounted for the other half. While much of the increase in volume and intensity went to provide real benefits to patients, there was considerable unnecessary utilization of Part B services.

Medicare Secondary Payer (MSP) Program

Another effective element of the multifaceted campaign to protect the fiscal integrity of the Medicare trust funds is the Medicare secondary payer program, which produced more than \$1.4 billion in savings in FY 1988. Under the program, HCFA seeks repayment of mistaken primary payments made in situations where a third party payer should have made primary payment. In FY 1988, particular emphasis was placed on recoupment in cases where employer group health plans should have made primary payment for services provided to employed individuals and their spouses aged 65

and older. Medicare sought these repayments from the insurers and third party administrators responsible for making payment under the employer plan. When insurers and third party administrators were reluctant to repay Medicare and cited contractual and other procedural reasons for their refusal, HCFA informed them of their responsibilities under the law.

Part A Quality Assurance Reviews

HCFA employed its Part A quality assurance review (QAR) throughout the fiscal year to examine how accurately 26 of the fiscal intermediaries processed prospective payment system (PPS) bills for inpatient care covered by Medicare. The review detected and corrected errors that would have resulted in an estimated \$286 million in mispayments nationally based on the error rates at the intermediaries reviewed. The review program was adapted to evaluate the performance of intermediaries in handling deductibles and coinsurance before and after the Part A provisions of the catastrophic coverage act take effect January 1, 1989. HCFA designed a program to monitor implementation of Medicare catastrophic provisions to ensure that beneficiary expenses and other pertinent financial data are accurately captured, recorded, and used by intermediaries, carriers, and HCFA.

Another program introduced during the fiscal year was designed to validate key data on the Provider Specific File, which is critical in calculating the amount of the PPS payment to institutional providers. This enhanced oversight resulted in an increase in the accountability for the accuracy of data developed by Medicare intermediaries as well as more effective monitoring by HCFA of the validity of the data.

Part B Quality Assurance Activities

Part B quality assurance programs were maintained at all carrier sites during the fiscal year, with the result that the national payment error rate declined from 1.4 percent in FY 1987

to a new low of 1.1 percent. Eighteen processing sites reduced the error rate by five percent from the previous year.

Even though considerable success was realized in reducing payment errors, HCFA pursued several activities during the year to further improve quality assurance, including the development of a new quality assurance data system. It provides for greater flexibility and a complete data base for corrective action analysis, and will be accessible to Medicare carriers and HCFA central and regional office staffs. The system will be implemented in 1989. HCFA also developed and tested at three carrier sites a computerized editing program to measure the accuracy of the annual reasonable charge update. The program is to be implemented nationwide for the 1989 reasonable charge update.

Operational Reviews

Several operational reviews were undertaken in FY 1988, including an assessment of the effectiveness of nationally mandated and local carrier medical review screens, and a review of the peer review organization/fiscal intermediary/carrier adjudication processes for PRO denials or adjustments. A third review looked at the medical necessity and reasonableness of payments for hospital radiology, laboratory, emergency room, and physical therapy services provided to outpatients. A fourth focused on the physician global service package studies for cataract extraction, and coronary artery bypass grafts.

The contractor adjudication system review was in response to a long-standing concern within HCFA about the timeliness and accuracy of the PRO denial/adjustment process. The study tracked PRO adjustment cases from the PRO case file through contractor adjudication (at both Part A and B contractors). The study assessed contractor compliance with program regulations and policies, timeliness and accuracy of transmitted PRO data, and contractor adjustment actions, and the dollar impact of

adjudication process problems. Study findings identified problems in transmitting PRO adjustments to the contractors and delays in processing Part B adjustments. Recommendations for improving communications between the parties were made, resulting in the publication of new program instructions and improved operations.

Physician Payment Studies

The physician global service package studies, begun in 1987, involved defining and/or bundling a standard package of services (pre-, intra-, and post-operative) for a typical Medicare beneficiary for six surgeries. Each study involved conducting extensive literature searches on the surgical topic, performing in-depth analyses of Part B beneficiary file data, developing a preliminary global package (Phase I); presenting the global package to a panel of expert physicians and compiling their comments and recommendations (Phase II); computing the average and the maximum payment amount for each surgery (pricing out the package), and determining the extent of variance of the package with current carrier policies (Phase III). Two surgeries (cataract extraction and coronary artery bypass graft) were planned as a three-phase study, and because of staffing constraints and competing priorities, four surgeries (transurethral resection prostatectomies, major hip reconstruction, hernia repair, pacemaker), were planned as a two-phase study. The following is a brief summary of the work that was in progress in FY 1988:

- **Cataract Extraction Study:** This study was the furthest developed (Phase III) in FY 1988 as work centered on extensive programming and analyses to "price out" a package of services typically associated with cataract surgery. Savings estimates and other recommendations were planned for early FY 1989.
- **Coronary Artery Bypass Graft (CABG) Study:** The cleanup of the CABG database

(Phase III) was completed during the fiscal year and the analyses of other services billed by the primary surgeon, anesthesiologist, and assistant surgeon were in process. At the close of the fiscal year, computer programs were being developed to calculate allowed charges and prevailing charges both on a carrier-by-carrier basis and nationally. A presentation of the results of the review were planned for early in FY 1989.

- **Transurethral Resection Prostatectomies (TURPS) Study:** Work on the TURPS study was advanced as HCFA completed the data analysis and data package phase (Phase I) for the expert physician panel (Phase II). The panel consisted of practicing urologists and a representative from the American Urological Association. The panel reviewed the data and recommended a package of services which are usually provided to a typical TURP patient. A final presentation on study recommendations was planned for early FY 1989.
- **Major Hip Reconstruction, Hernia Repair, Pacemaker Studies:** HCFA began Phase I of the global service study by conducting an extensive literature search on major hip reconstruction, hernia repair, and pacemaker surgeries. This phase also included an indepth analysis of certain Part B beneficiary file payment data on these surgeries. Presentations of the data analyses to expert physical panels were scheduled for the first quarter of FY 1989.

Carrier Prepayment Medical Review Screens

In a study of carrier prepayment medical review screens, HCFA analyzed the cost-effectiveness of national screens and local screens which could be considered for national implementation. The accuracy of information submitted by the carriers in their quarterly medical review reports to HCFA was also verified. Study findings included recommenda-

tions for improving the effectiveness of screens for physician hospital visits, comprehensive office visits and concurrent care, and for identifying local screens that might effectively be used as national screens. Local screens were recommended for seatlift chairs, automated multichannel laboratory tests, extended office visits, cerebrovascular arterial studies, eye examinations, chest X-rays, consultations, extended hospital visits, and second assistants-at-surgery. Action on the recommendations was scheduled for early in the next fiscal year.

Contractor Performance Evaluation Program

HCFA'S Contractor Performance Evaluation Program (CPEP) was used to rate the performance of Medicare contractors. CPEP incorporates numerous performance standards designed to reduce inappropriate expenditures. In FY 1988, 31 of the 60 total Part A standards and 29 of the 69 total Part B standards were designed to evaluate contractor performance with respect to payment safeguards. Selected standards included Medicare secondary payer goals, cost-effective medical review and audit programs, detection of fraud and abuse cases, limiting the incidence of provider overpayment, and ensuring that no payments are made to excluded, terminated or suspended providers or physicians. All 57 intermediaries and 41 of 48 carriers met the CPEP standards. The seven carriers failing to meet the standards were required by HCFA to establish corrective action plans to remedy their performance deficiencies.

HCFA utilizes the Uniform Contractor Evaluation Program (UNICEP) as the primary instrument to evaluate the quality of Medicare contractor performance in the area of auditing and settling Medicare cost reports (hospitals, home health agencies, and skilled nursing facilities). The UNICEP produces a score that is used in the CPEP.

During FY 1988, HCFA's regional offices performed a total of 512 reviews and identified approximately \$17 million in improper pay-

ments to Medicare providers. Most dollar findings were identified through reviews of prospective payment settlements. The greatest dollar error occurred because costs that should have been absorbed by the providers as operating costs were allowed as pass-through costs to Medicare.

Prospective Payment System Refinements

Medicare operations associated with the prospective payment system (PPS) during FY 1988 focused on implementing provisions of OBRA 87. The provisions made changes affecting Medicare payments to hospitals, including an increase in the payment rate for inpatient hospital services; separate payment rates for cost outliers for burn center diagnosis related groups; and the establishment of regional minimums for the PPS standardized payment amounts.

To implement these provisions, HCFA developed a special computer software adjustment program to be used by Medicare intermediaries. It was designed to ascertain the proper adjustment amount for Medicare claims and to provide a listing by provider of total amounts to be reimbursed. Implementation of this special payment adjustment system is credited with saving the Medicare program \$4.5 million in claims processing costs in FY 1988.

Rate of Increase in PPS Payments and Rate-of-Increase Ceiling

On September 1, 1987, HCFA published in the Federal Register the final FY 1988 PPS update factor and the update factor for the rate-of-increase ceilings for PPS-excluded hospitals. The Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 delayed the applicable percentage increase (which was 2.7 percent) and provided a zero percent increase for 51 days. The national/regional blend of the Federal rate and the hospital-specific-Federal rate was also extended by 51 days. These provisions expired on November 21, 1987, and the provisions of the

September 1, 1987, final rule governing the updates and the transition became effective. The final rule provided for the following updates to the PPS standardized amounts beginning with discharges on or after April 1, 1988:

- 3.0 percent for hospitals located in rural areas;
- 1.5 percent for hospitals located in large urban areas; *and*
- 1.0 percent for hospitals located in other urban areas.

A large urban area is an urban area with a population of more than 1 million persons. Any New England County Metropolitan Area of 970,000 is also classified as a large urban area. Prior to enactment of this legislation, hospitals were classified as either rural or urban. For PPS-excluded hospitals the update factor was 2.7 percent for the remaining 315 days of a hospital's cost-reporting period.

The law further provided for the establishment of a "regional floor" whereby a hospital's payments are based on the greater of the national average standardized amount or the sum of 85 percent of the national average standardized amount and 15 percent of the average standardized amount for the respective region. Some hospitals in all three classifications (rural, large urban, other urban) benefited from this provision.

The September 1 final rule also incorporated capital-related costs into the PPS effective with discharges occurring on or after October 1, 1987. However, OBRA 87 imposed a moratorium on paying for capital costs under PPS until FY 1992.

Inclusion of Puerto Rico Under PPS

Another provision of OBRA 87 included eligible hospitals in Puerto Rico in the PPS effective with discharges occurring on or after October 1, 1987. The payment per discharge under PPS for hospitals in Puerto Rico is the sum of 75 percent of the Puerto Rico urban or rural standardized rate and 25 percent of a national standardized rate.

Revision of Diagnosis Related Group (DRG) Classifications

Major DRG classification revisions introduced in FY 1988 included the re-configuration of the alcohol and drug abuse DRGs and elimination of age as a criteria for classification. In addition, beginning with FY 1988 discharges, the DRG classifications and weighting factors will be adjusted annually.

Hospital Wage Index Methodology

Also revised during the fiscal year was the method used to compute the national average hourly hospital wage. For FY 1988, the national average hourly wage was calculated by dividing total wages for all PPS hospitals by the total paid hours. The national average hourly wage serves as the basis for indexing the area wage levels. The new method of calculation assures minimal distortion in the national average when area wage data are adjusted. A blended wage index using 1982 and 1984 wage data was implemented in FY 1988.

Clinical Diagnostic Laboratory Services

Payment for clinical diagnostic laboratory services is made at 100 percent of the lesser of (1) the actual charge billed by the laboratory, (2) the fee schedule amount established by local carriers, *or* (3) the national limitation amount.

Section 4064 of OBRA 87 requires that for a laboratory test performed on or after April 1, 1988, the national limitation amount is reduced from 115 percent to 100 percent of the median of all the local carrier fee schedules for the test. In addition, the fee schedules for automated tests and for 11 tests formerly subject to the lowest charge-level provision were reduced by 8.3 percent.

Another provision of OBRA 87, section 4051, set new limits on Medicare payments for diagnostic tests other than clinical laboratory tests. Prior to the enactment of section 4051, these diagnostic tests were reimbursed in

accordance with the traditional, customary and prevailing charge criteria and could be billed by either the supplier performing the test or the physician ordering the test. Physicians billing Medicare for tests performed by an outside supplier often charged more than what the supplier charged for the tests. Under the new law, Medicare payment for diagnostic tests for which a physician bills but does not personally perform or supervise, will be the physician's actual cost in purchasing the test or, if lower, the supplier's reasonable charge for the test. Medicare's applicable deductible and coinsurance amounts are to be deducted from the payment.

Psychologist Services

To expand Medicare beneficiary access to mental health services, Congress established Part B coverage for clinical psychologist services rendered at community mental health centers (CMHC) under section 4077(b) of the OBRA 87. Congress mandated payment to be made at 80 percent of the lower of the actual charge or the amount specified under a fee schedule to be developed by the Secretary. The Act also required payment to be made on an assignment basis, i.e., beneficiaries could not be charged more than the amount Medicare determines to be reasonable. To ensure that the fee schedule would not exceed payment levels for similar services furnished by psychiatrists and other psychologists, the locality-based fee schedule sets payment for therapeutic services rendered by psychologists in CMHCs at 80 percent of the adjusted prevailing charge for Medicare-participating psychiatrists. Diagnostic services by psychologists in the centers are set at 90 percent of the adjusted prevailing charge for psychologists in independent practice.

Immunosuppressive Drug Coverage

Medicare coverage was also expanded during FY 1988 to include immunosuppressive drugs for transplant patients during the first year after surgery.

Expansion of Swing Bed Program

In compliance with section 4005(b) of OBRA 87, HCFA issued instructions expanding eligibility for participation in the Medicare swing bed program to rural hospitals having fewer than 100 beds. At the same time, the agency implemented additional conditions affecting payments for extended care services furnished by participating swing bed hospitals with between 50 and 99 beds. The new conditions require, among other things, that extended care patients in these swing bed hospitals be transferred within 5 days if there is an available bed in a skilled nursing facility in the geographic area. The transfer is not required if the patient's physician certifies that it is not medically appropriate.

Payment for Outpatient Surgery at Eye Specialty Hospitals and Eye and Ear Specialty Hospitals

Instructions were issued during the fiscal year to implement the new payment provisions that were enacted under section 9343(a) of OBRA 86 for ambulatory surgical procedures performed in hospitals on an outpatient basis. This was done in conjunction with preparations for the implementation of section 4068(a) of OBRA 87 which allows certain qualified eye hospitals and eye and ear hospitals to receive payment for facility services furnished in connection with ambulatory surgical procedures. For FYs 1989 and 1990, payment will be calculated on a blended payment of 75 percent hospital specific and 25 percent ambulatory surgical center amount. In subsequent years, payment will revert to a 50/50 percent blended amount.

Hospital Outpatient Services

A study begun in FY 1987 of four hospital outpatient services was continued during the fiscal year in an effort to determine whether hospitals were billing for inappropriate services

or for outpatient services not covered by Medicare. The study focused on laboratory, radiology, emergency, and physical therapy services provided on an outpatient basis. Analysts reviewed medical and billing records at 40 hospitals and 281 physicians' offices to obtain information on more than 1,500 Medicare beneficiaries. The medical review of these records was performed by the SuperPRO. Action plans addressing inappropriate payments identified by the study will be introduced early in FY 1989 and are expected to produce significant savings for the Medicare program. In a related action, HCFA developed instructions during FY 1988 to implement section 4066 of OBRA 87 which governs payments to hospitals for outpatient radiology services. Section 4066 directs that payment is to be based, in part, on what Medicare would have paid for the same service if it had been performed in a physician's office in the same locality. To facilitate implementation of this new requirement, HCFA developed standardized computer software and distributed it to all Medicare intermediaries.

Provider-Based Home Health Agencies, Hospices Assigned to Designated Regional Intermediaries

HCFA published a final rule in the May 19, 1988, edition of the Federal Register requiring the assignment of provider-based home health agencies (HHAs) and provider-based hospices to the same regional home health intermediaries that were previously designated to serve free-standing HHAs. The final rule, which became effective June 20, 1988, is intended to achieve greater consistency in the administration of the HHA benefit under the Medicare program in compliance with the Deficit Reduction Act of 1984. Under this final rule there is a permanent split in intermediary responsibility. The designated regional home health intermediary is responsible for processing bills, making cover-

age determinations and bill payments. Audit, cost-report settlement, and other fiscal functions, such as determining interim rates and overpayments, remain the responsibility of the intermediary serving the parent provider. The provider-based HHA and hospice transfers were to begin on a State-by-State basis October 1, 1988, and to be completed by April 1, 1989. More than 1,300 provider-based HHAs and more than 100 provider-based hospices are to be transferred to the designated regional home health intermediaries.

In response to the final rule authorizing the assignment of provider-based HHAs to the designated regional home health intermediaries, 40 HHAs filed a lawsuit on September 28, 1988, against the Federal government (New Britain General Hospital Home Health Agency, *et al*, versus Otis Bowen, Secretary, DHHS) in the United States District Court for the District of Columbia. They were subsequently joined in the lawsuit by an additional 46 HHAs. The HHAs allege that the Federal government failed to apply the proper standards, criteria and procedures designed to assure that the impending provider-based HHA transfers would result in the more efficient and effective administration of the Medicare program. It is further claimed that the Federal government applied criteria and standards which were improperly promulgated. On September 30, 1988, a District Court judge denied an HHA motion for an order temporarily restraining HCFA from proceeding with the transfers.

Improved Home Health Review

HCFA continued to conduct quarterly meetings with regional home health intermediaries to provide guidance to further improve the accuracy and consistency of home health reviews. HCFA also met periodically with the home health industry to obtain input and recommendations on home health issues. As part of the effort to improve communications, HCFA published the Home Health Agency Manual and revised the home health provisions

of the Intermediary Manual during the fiscal year to provide Medicare beneficiaries, intermediaries, and HHAs with a clearer understanding of Medicare's rules for home care services covered by the program. HCFA is also in the process of publishing regulations revising the HHA conditions of participation and developing more detailed rules governing eligibility and coverage. When completed, these initiatives will make the Medicare home health benefit more accessible to beneficiaries.

Replacement Contractors

In April 1988, Prudential Insurance Company announced its intention not to renew its Medicare contracts effective December 1988. Prudential is one of the largest Medicare contractors, as it processes approximately 8 percent of the national volume of Medicare claims (over 31 million bills) and pays out about \$2.5 billion in Medicare benefits. It services hospitals, skilled nursing facilities, physicians and other health care providers in New Jersey, North Carolina and Georgia. It also is one of the designated regional contractors that processes bills from home health agencies and hospices.

HCFA selected Blue Cross Blue Shield United of Wisconsin to replace Prudential as the designated regional home health intermediary in the New York region, comprising New York, New Jersey, Puerto Rico and the Virgin Islands. At the same time it was announced that the New Jersey hospital and skilled nursing facility workload is to be reassigned to Blue Cross and Blue Shield of New Jersey, Inc., and Aetna Life and Casualty Company. For the Part B workloads, Pennsylvania Blue Shield was selected as the Medicare carrier for New Jersey, Equicor, Inc., as the carrier for North Carolina, and Aetna Life and Casualty Company as the carrier for Georgia.

Blue Cross Blue Shield United of Wisconsin will be required to establish claims processing staff in the region to provide localized services to the home health agencies and hospices it will serve. All the replacement carriers will be

required to maintain a substantial presence with a walk-in office for beneficiaries in the respective States. Additionally, they will be required to have a physician licensed to practice medicine in the respective States on their staffs to serve as liaison with the medical community.

Beneficiary Inquiry Workloads at Carriers and Intermediaries

During FY 1988, Medicare intermediaries handled 1,699,425 beneficiary inquiries (1,297,227 telephone; 357,347 written; and 44,851 walk-in) and 1,571,502 inquiries from providers (906,503 telephone; 662,826 written; and 2,173 walk-in). The number of beneficiary inquiries increased 8.2 percent from the FY 1987 level.

Beneficiary inquiries to Medicare carriers increased by 3.3 percent to 16,738,255 (14,265,101 telephone; 2,063,337 written; and 409,817 walk-in). Carriers also handled 7,161,169 provider inquiries (4,315,881 telephone; 2,828,143 written; and 17,145 walk-in). This represented an 8.8 percent increase in provider inquiries over the previous 12 months. Beneficiary and provider inquiries totaled 23,899,424.

Medicare carriers were reminded of the importance of the requirement that they provide beneficiaries with satisfactory local and toll-free telephone service. Carriers must meet busy signal and call acknowledgement standards for telephone service, and are required to electronically monitor telephone service performance. Monthly performance reports are required, and if a carrier does not meet minimum standards, corrective action is taken by the appropriate HCFA regional office. During the fiscal year, carriers maintained an average 9.5 percent all-trunks-busy (ATB) level of service in comparison with a standard of not more than 20 percent ATB.

Participating Physician Program

DEFRA 84 created the participating physician program under which physicians and suppliers

may make a voluntary choice each year to accept assignment on all Medicare claims for the following year. Those who accept assignment agree to accept Medicare approved amounts as payment in full for their services regardless of the actual charges. On assigned claims they bill the beneficiary only for applicable deductible and coinsurance amounts.

OBRA 87 provided for bonuses to carriers who increase the participation rates of the physicians and suppliers in their service areas. During FY 1988, 40.7 percent of the physicians and 21 percent of the suppliers signed Medicare participation agreements.

Unique Physician Identifiers

Progress was made during the fiscal year toward implementing section 9202(g) of COBRA 85, which requires HCFA to develop a system of unique physician identifiers. Specifications were developed for the system, and HCFA successfully conducted a competitive procurement for a contractor to establish and maintain the system. Contractual arrangements were also agreed to with the American Medical Association (AMA) for use of its physician database and for assistance in identifying all physicians providing services for which Medicare payment is made. Long-term plans call for use of the unique physician identification numbers in claims payment to facilitate tracking of program expenditures and physician practice patterns.

Skilled Nursing Facilities

Operating instructions for skilled nursing facility (SNF) coverage were revised by HCFA during the fiscal year to provide more illustrative examples of how the coverage rules apply to various situations. The intent was to improve the consistency of claims decisions from one intermediary to another and to give the staffs at SNFs a better understanding as to which services are covered by Medicare.

Medigap Insurance

In enacting the Medicare Catastrophic Coverage Act, Congress recognized the need for changing Medicare supplemental insurance policies (Medigap insurance) to conform with the new Medicare benefit structure and included a provision in the law requiring the National Association of Insurance Commissioners (NAIC) to revise its model standards for the policies. The NAIC completed this task on September 20, 1988, within the 90-day time limit established by Congress. HCFA is now developing regulations to implement changes in the Federal rules required by the catastrophic coverage act and the new NAIC model standards, which are incorporated by reference into Federal law. The burden of implementing these changes falls mainly on State insurance regulators, however. The Supplemental Health

Insurance Panel is in the process of reevaluating all State regulatory programs for compliance with the new standards. HCFA's enforcement role (beyond the development of regulations and providing staff assistance to the Supplemental Health Insurance Panel which approves or disapproves State programs as having standards equal to or more stringent than the Federal standards) would come into play only if State actions did not result in regulations as specified in the law.

Medicare Catastrophic Coverage

HCFA completed plans for large-scale systems to support implementation of the provisions of the Medicare Catastrophic Coverage Act and provided cost estimates for a variety of approaches to putting them into effect.

Research, Demonstrations and Evaluations

Introduction

For a substantial period of time, the costs of health care services have been outpacing the rate of inflation in the general economy. This means that not only has the absolute number of dollars spent on health care increased rapidly, but also the proportion of the gross national product (GNP) related to health care has increased. This trend continues to be a matter of primary concern to HCFA as the leading purchaser of health care in the United States. Since the establishment of HCFA, the overall purpose of its research and demonstration (R&D) program has been to find ways to moderate or control this inflationary trend and to ensure that every dollar is used effectively in the service of Medicare beneficiaries.

HCFA's R&D activities provide knowledge to enable the Administrator, the Secretary, Congress, and other interested parties to make informed and rational decisions regarding HCFA programs and policies.

The agency's existing research, demonstration and evaluation activities include projects to test new payment, coverage, eligibility, and program management approaches, as well as research and evaluation studies of the impact of HCFA programs on health care costs, program expenditures, beneficiary access to quality health care services, and the economics of the health care industry. HCFA is extensively involved in the creation of new and improved data sets to support these ongoing R&D activities. These projects result in knowledge about the basic structure, incentives, costs, and effects of HCFA programs and policies and make possible to refine existing policies, simulate or test various program changes on a trial basis and develop innovative financing and delivery systems.

In addition to its intramural projects, HCFA spent almost \$29 million for grants and contracts to conduct research, demonstration, and evaluation projects during the fiscal year. Of this amount, \$17 million went to the approximately 150 studies that continued into FY 1988 from previous years and \$12 million went to fund 95 new projects. The seven program areas addressed were: alternative payment systems; quality of care; physician payment; hospital payment; program efficiencies, analyses and refinements; beneficiary awareness and prevention; and subacute and long-term care. More specific information on individual projects can be found in the Status Report: Research and Demonstrations in Health Care Financing Fiscal Year 1988 Edition.

Alternative Payment Systems (\$6 Million)

Prior R&D activities involving health maintenance organizations (HMOs) determined that alternative delivery systems and alternative risk payment mechanisms are cost-effective and offer Medicare beneficiaries the opportunity for improved benefits over the existing fee-for-service system. With the implementation of TEFRA HMO provisions, there was a need to go beyond HMO and competitive medical plan (CMP) models and test other delivery and financing systems that enhance competition among providers and yield potential savings to the program.

Fifty-one studies testing alternative payment methods, including 14 new studies, were in progress in FY 1988 in such areas as outpatient services payment, end-stage renal disease payment, the Medicare insured group demonstrations, and State programs for long-term care. Projects tend not to be limited to one segment of the Medicare population or to one

aspect of the health care delivery and financing system. Within this area, researchers attempt to identify, test and evaluate cost-effective alternative delivery and/or financing systems that affect multiple segments of the program. Therefore, the agency focused on those projects designed to test systems capitating payments for various types of services and those projects that tried to refine or test alternatives to the current methods and bases for payments to capitated systems. HCFA also continued evaluations of a series of HMO demonstrations and implemented an evaluation of the TEFRA HMO and CMP programs.

Major new initiatives during the year included:

Clinical Refinement of Diagnostic Cost Group Model (Brandeis University Research Center). The objective of this project is to develop conceptual clinical models identifying patterns of hospitalization data that can be used to categorize individuals whose continuing needs for health care services will result in higher future costs.

Medicare Participating Heart Bypass Center Demonstration Design (Project Hope Research Center). The goal of this task is to help HCFA plan and implement a preferred provider organization demonstration for heart bypass procedures.

Capitated Community Nursing Organizations (Project Hope Research Center). This study will assist HCFA in designing a project to provide Medicare payment on a prepaid capitated basis to community nursing organizations.

Medicare Payments to Health Maintenance Organizations: Beyond a Local Fee-For-Service Methodology (The Urban Institute). This project will investigate whether favorable selection by HMOs in areas of high HMO penetration affects the health status and cost of

those Medicare beneficiaries remaining in the fee-for-service sector.

Amalgamated Medicare Insured Group (Amalgamated Medical Life Insurance Company). This project will unify all aspects of program administration, including Medicare Parts A and B and Medicare supplement benefits, under the auspices of Amalgamated Life. Funding will be provided through a capitated rate paid by HCFA, employee contributions, and enrollee premiums. By using managed health care systems and provider negotiation leverage resulting from a large retiree population, costs to all payers are expected to be reduced.

Quality of Care (\$4.5 Million)

Program changes have the potential to impact on the quality of care provided to program beneficiaries. In order to assess the impact of such changes, as well as to ensure continued access by program beneficiaries to quality care, it is essential that valid quality of care measures for different treatment settings be developed. Seventeen studies from previous years continued into FY 1988. The eight new quality of care studies in FY 1988 were:

Using Case-Mix Systems to Measure Quality of Care (Brandeis University Research Center). This project involves three separate activities:

- Using the hospital medical illness severity grouping system data base to examine the system's ability to predict and explain 30-day and 60-day post-admission mortality.
- Examining the relationship between severity scores produced through the computerized severity index costs of hospital admissions and in-hospital deaths.
- Planning and hosting symposia to discuss issues relating to the measurement of quality of care.

¹Under cooperative agreements with four Research Centers (RAND, Project Hope, The University of Minnesota, and Brandeis University), HCFA arranges for the undertaking of various studies and projects. The agenda for each Center is jointly developed by HCFA and the Center on an annual basis.

Outcome Measures for Assessment of Hospital Care (University of Minnesota Research Center). This project explores the usefulness of outcome measures other than mortality in assessing the effectiveness of hospital care.

Option Paper on Collection of Health Status Information on Consecutive Cohorts of Medicare Beneficiaries (Project Hope Research Center). This project will explore the feasibility of: collecting data on the health status of beneficiaries as they become entitled to Medicare; collecting data on changes in the health status of beneficiaries over time; and undertaking a demonstration to evaluate the impact of health risk assessment on beneficiary health and Medicare use.

Development of Ambulatory Surgery Quality of Care Measures and Monitoring Strategy (Brandeis University Research Center). This project will produce a conceptual report addressing methods that could be used to develop approaches for measuring the quality of ambulatory surgery. This research will provide HCFA with decisionmaking information concerning options, strategies, and approaches in developing ambulatory surgery quality-of-care measures.

Development of Methodologies for Technical Assessment and Quality Assurance Based on the Medicare Claims Data System (Dartmouth College). This project, which involves the collection and analysis of data on patients who underwent coronary angiography in a New England hospital from 1984 to 1986, will allow HCFA to pursue research methodologies that should be used in studies relating to effectiveness of medical and surgical interventions in the Medicare population and would help validate the utility of Medicare claims data in studies of this type.

Development of Outcome-Based Quality Measures for Home Health Services (Center for Health Policy Research). The purpose of this contract is to develop and test outcome-based measures or indicators of quality for Medicare home health services. The measures

are to be reliable and valid for use in monitoring and comparing quality of home health care across agencies, recognizing possible confounding factors such as case mix.

The Use of Medicaid Reimbursement Data in the Nursing Home Quality Assurance Process (Center for Health Systems Research and Analysis). This project will assess the feasibility of using Medicaid reimbursement data to target facilities and residents in the nursing home quality assurance survey process. These data appear to hold considerable promise in helping target facilities for more intensive review, identifying specific areas of deficient care, and identifying individual residents for more detailed review.

Medicaid Quality of Care Study (Systemetrics Inc./McGraw Hill). This study will examine the appropriateness, necessity, and effectiveness of selected medical treatments and surgical procedures for Medicaid patients.

There are many relevant issues within the quality of care area. HCFA has a continuing interest in quality issues as they relate to:

- (1) the impact of payment mechanisms, such as the PPS or the ESRD composite rate, on quality of care;
- (2) the impact of severity of illness on health care outcomes;
- (3) the effectiveness of alternative medical interventions on the health of Medicare beneficiaries; and
- (4) access to and quality of services in subacute care settings, such as home health and skilled nursing care.

Physician Payment (\$5 Million)

HCFA's physician payment research agenda is based on a commitment to understand better the underlying reasons for the rapid growth in Medicare spending for physician services and to implement reforms to the current system. The research is intended to support proposals for reform of Medicare physician payment policy and be responsive to the increasing

interest on the part of Congress in developing a more rational payment system. The bulk of the research focuses on the issues of pricing and utilization, intensity, and coding.

Seven extramural studies from previous years continued in FY 1988, including major studies of resource-based relative value scales and projects supporting improvements of Part B data. In addition, considerable indirect support to the Physician Payment Review Commission staff was provided.

Although long-term growth trends in Medicare physician spending slowed somewhat between FYs 1984 and 1986, by the end of FY 1987 the largest increase ever in Medicare Part B premiums was announced. The increase was driven by growth in Part B costs. To better understand what is fueling the increase in Medicare physician spending, HCFA has committed more external and internal redirection of research resources to physician payment research. To this end, 21 new studies were implemented, including:

Specialty Differentials Across Localities (The Rand Policy Research Center). This study has two objectives. The first is determining the presence and size of physician payment differentials between specialists and nonspecialists across localities for a given set of procedures. This aspect will also focus on the criteria used by carriers in defining specialists. The second objective involves an analysis of the effect of physician payment rate differentials across localities on the volume of services provided by physicians.

Physician Preferred Provider Demonstration (University of Minnesota Research Center). This project involves the planning and implementation of a preferred provider organization demonstration for physician services offered to Medicare beneficiaries as a program option.

Medicare Physician Experience Differentials (The Rand Policy Research Center).

Under current Medicare policies, new physicians are reimbursed at 80 percent of the prevailing rate for experienced physicians. This study will attempt to analyze whether the size of the payment differential is appropriate and whether current policies provide comparable incentives to encourage new and experienced physicians to treat beneficiaries.

Determinants of Cost of Care: The Influence of Physician Style versus Patient Characteristics (University of Minnesota Research Center). Significant variations in the cost of managing patients with the same diagnosis have been documented. This study will help determine what percent of variance in the cost of care is caused by physicians' unique practice patterns and what percent is caused by differences in patient population characteristics and disease severity.

Analysis of Medicare Customary Charge Distribution (HK Research Corporation). The goals of this project are:

- To develop a data base on customary charge distributions in four States for multiple years.
- To analyze the distribution of customary charges relative to the prevailing charges with pricing locality over time.
- To simulate the redistributive effects of potential changes in physician payment parameters.

Development of Physician Malpractice Index Reports (Metrica, Inc.). The project seeks to develop three types of indices of physician malpractice insurance costs, i.e., fixed liability limits, actual premium expenditures by physicians, and constant risk.

1988 Survey of Physicians' Practice Costs and Incomes (National Opinion Research Center). The contractor will interview 6,000 physicians on the cost of practice, productivity, malpractice insurance, volume/intensity of certain procedures, and out-of-pocket costs to Medicare beneficiaries.

Hospital Payment (\$5 Million)

HCFA continued to investigate issues related to the refinement and expansion of the PPS during FY 1988, the fifth year of prospective payment. Almost 30 other extramural hospital payment studies begun in prior years continued into the fiscal year. These studies, which have been discussed in greater detail in previous annual reports, focus on a range of hospital payment issues, including an analysis of the impact of PPS, the refinement of the patient classification system, the extension of PPS to types of hospitals and units that are currently excluded from the system, and the development of a PPS for outpatient care.

Intramural research being conducted at HCFA has addressed many hospital payment issues, such as malpractice costs, the cost of providing services for indigent populations, the indirect cost of medical education programs, payments for outlier cases, methods for incorporating capital costs into the PPS payment rates, and the recalibration of the DRG relative weights.

Fourteen new extramural hospital payment research studies were awarded including:

A DRG-Based Case-Mix Analysis of Oncology Care in Comprehensive Cancer Centers (Brandeis University). The short-term goal of this project is to improve the ability of the current DRG system to account for variability within DRGs containing cancer diagnosis. The long-term goal is to develop a classification methodology that can discriminate among admissions with different resource requirements for three types of cancer: colon, breast, and lung.

DRG Outlier Payment Effect on Quality of Care (The Rand Policy Research Center). The purpose of this research is to use detailed clinical data on 15,000 patients to determine whether outlier payments have any effects on levels and quality of care and what factors are responsible for extremely expensive or long hospital stays.

Interaction Between Medicare Payments and Nursing Shortages (Project Hope Research Center). This study will examine the interaction taking place between PPS and the nursing shortage being reported by hospitals in many areas of the country. Issues to be addressed include possible causes for the shortage, the impact on quality of and access to care, and the contributions of PPS relative to other influences.

Analysis of Case-Mix Growth Among Hospitals (The Rand Policy Research Center). The case-mix index (CMI) measures the relative costliness of a group of Medicare patients. Theoretically, increases in the CMI can be separated into "real" increases and coding changes. Real increases are caused by increases in the severity of illness in the patient population or by changes in the treatment patients receive. This study is intended to separately measure changes in the CMI resulting from real and coding changes.

Utilization Effects of Rural Hospital Closures (The Johns Hopkins University). The purpose of this project is to conduct a preliminary analysis of the effects of rural hospital closures on health services utilization by Medicare beneficiaries.

Prospective Capital Payment: Refinements and Impacts (Center for Health Economics Research). Congress imposed a moratorium on prospective capital payment as a result of concerns about why some hospitals were projected to be big "losers" under the proposed FY 1988 prospective Medicare capital payment system. This project examines the proposed policy and develops and evaluates potential refinements.

Medical Assistance Facility Demonstration Project (Montana Hospital Research and Education Foundation). The Foundation will be conducting a demonstration of the utility and desirability of medical assistance facilities (MAFs) as a new type of frontier health care

facility. MAFs, which provide low-intensity acute care services to short-term inpatients, are intended to maintain access to basic acute and emergency care services.

Program Efficiencies, Analyses, and Refinements (\$4 Million)

Congress has prompted major changes in the past few years to improve the effectiveness and efficiency of the Medicare program. Research on and evaluation of these changes, as well as on factors influencing program performance, provide the information on health care expenditures and utilization patterns of Medicare beneficiaries necessary to achieve more cost-effective program operations. Essential to this effort is the improvement of existing Medicare data bases. Several aspects of program performance have been studied to improve understanding of them. Factors influencing utilization of particular types of services and the characteristics of certain categories of beneficiaries were examined.

Twenty-seven projects from previous years continued into FY 1988 and 19 new studies were funded. Among the latter were:

Evaluation of Medicare Expenditures for Durable Medical Equipment (Center for Health Economics Research). This research is intended to provide HCFA with information on whether Medicare is paying fair market rates for durable medical equipment; that is, whether Medicare reimbursements are above competitive prices.

Predictors of Cost and Success in Kidney and Heart Transplantation (Battelle Human Affairs Research Centers). This project will examine the patient and organizational characteristics that determine successful kidney and heart transplantation outcomes. Using multivariate life-table methods, data from the Medicare program will be combined with information from surveys of transplant facilities to construct a model of transplant facility effectiveness.

International Comparative Data and Analyses on Health Care Financing and Delivery Systems (The Organization for Economic Cooperation and Development). The focus of this project is to develop, update, and refine an internationally comparable data base on health care spending patterns, prices, utilization, and delivery system characteristics.

Small Business Innovation Under the Small Business Innovative Research program, HCFA funded several low-cost studies. Among these were:

DRG-Specific Resource Management Software for Hospitals (John Rafferty and Associates). The objective of the project is to develop a software package for predicting and evaluating hospital resource use and needs on a DRG-group basis.

Acquired Immunodeficiency Syndrome (AIDS) Comprehensive Monitoring System Pilot Project (Research Consultants). There are four objectives in this project:

- To identify the service components and the source of payment for AIDS and AIDS-related complex patients who receive care in alternative settings.
- To identify the services that are requested but are not available in alternative-care programs.
- To develop standard protocols for collecting units of service use and cost data in AIDS alternative-care settings.
- To develop a microcomputer-based system for monitoring and managing AIDS patients' costs in alternative settings.

Preventive Services and Beneficiary Awareness (\$2 Million)

Current coverage rules governing Medicare do not allow reimbursement for most preventive services. HCFA, however, continues to maintain an interest in the potential beneficial effects of particular preventive medical services through its research.

Nine extramural projects from previous years continued into FY 1988 and eight new projects were funded during the fiscal year. The new projects include:

Study of Inappropriate Use of Medications by Medicare Beneficiaries (University of Minnesota Research Center). This study will attempt to address the following questions:

- How prevalent is the inappropriate use of medication in the elderly population?
- Which medications are most likely to be prescribed inappropriately?
- Which interventions are most likely to lead to a reduction in appropriate medication use by the elderly?

Prevention Studies

Section 9314 of the COBRA 85 requires the Secretary to conduct, evaluate, and report on demonstration programs designed to reduce disability and dependency through the provision of preventive health services to beneficiaries. In partial response to this mandate, the following studies were initiated:

Cost Utility of Medicare Reimbursement for Preventive Services in an HMO (University of Washington School of Public Health and Community Medicine). This project will implement a randomized design to assess the cost savings and changes in health-related quality of life associated with providing a preventive-service package (annual health risk assessment, individual health promotion, and group counseling) for Medicare beneficiaries enrolled in Group Health Cooperative of Puget Sound.

Preventive Health Services for Medicare Beneficiaries: Demonstration and Evaluation (The Johns Hopkins University). This demonstration will provide preventive services to a representative population of beneficiaries residing in the eastern half of Baltimore City. The University will also

conduct a comprehensive evaluation to assess the cost effectiveness of providing preventive services.

Preventive Health Services for Medicare Beneficiaries (University of Pittsburgh). This demonstration will provide preventive services to beneficiaries residing in rural counties in western Pennsylvania. The University will also conduct a comprehensive evaluation to assess the cost effectiveness of providing preventive services.

Preventive Health Services for Medicare Beneficiaries, San Diego Demonstration Project (San Diego State University Foundation). Approximately 2,400 Medicare patients currently enrolled in the Secure Horizons HMO will be randomly assigned to either a treatment or a control group, with a subsequent evaluation to assess the cost effectiveness of providing preventive services.

University of California, Los Angeles, Medicare Prevention Demonstration (University of California). Approximately 1,600 beneficiaries who are current patients of The University of California, Los Angeles, university-based clinic will be randomly assigned to either a treatment or a control group, with a subsequent evaluation to assess the cost effectiveness of providing preventive services.

Subacute and Long-Term Care (\$2.5 Million)

HCFA continues to investigate and has expanded its examination of issues relating to subacute and long-term care. Studies focus primarily on the areas of: alternative payment and delivery, long-term care populations, case-management studies, and catastrophic coverage studies. A total of 24 studies initiated in previous years continued into FY 1988 and 11 new studies were initiated during the fiscal year. Among the new studies were:

Capitation Reimbursement for Frail Elderly (Brandeis University Research Center). This project will examine data on Medicaid nursing home certifiable beneficiaries as a means to analyze and refine the capitated reimbursement methodology being implemented in the congressionally mandated demonstration of a program for all-inclusive care for the elderly.

Financial Impact to Beneficiaries of Nursing Home Care (Brandeis University Research Center). The project will use the Urban Institutes' Transfer Income Model for State estimates and the Connecticut Nursing Home Inventory data base to calculate nursing home use and payments. In addition, the 1985 National Nursing Home Survey will be used to analyze several dimensions of nursing home use. From the collected data, estimates will also be made for the nursing home patients' spend-down provision.

New Jersey Respite Care Pilot Project (New Jersey Department of Human Services). This project was established to help individuals care for elderly and disabled family members who are at risk of institutionalization by providing services and support needed by both care recipients and care givers. The purpose of the study is to determine the extent to which the provision of respite care services will delay or avert institutional placement and enhance and sustain the role of the family in providing long-term care services.

Efficacy of Nursing Home Preadmission Screening (Brown University). The purpose of this project is to evaluate a nursing home preadmission screening methodology developed to identify those persons who would be institutionalized if community-based services were not available. The project will analyze the extent to which the screen accurately predicts the need for a nursing home level of care or an equivalent level of community care.

Research on AIDS Cost and Utilization Experience in New York and California Medicaid Programs (SysteMetrics, Inc.). The purpose of this project is to:

- Use epidemiological techniques to produce incidence analysis of AIDS over a 4 1/2 year period from October 1982 to March 1987.
- Study the eligibility patterns of AIDS patients in Medicaid.
- Develop a disease-staging algorithm for AIDS Medicaid patients.
- Provide a utilization and cost analysis of the population.

Studies on Rural and Inner City Health Care Issues

Section 4403(b) of OBRA 87, as amended by the Medicare Catastrophic Coverage Act of 1988, states:

"The Secretary of Health and Human Services shall establish an agenda of research and demonstration projects, relating exclusively or substantially to rural health issues or to inner city health issues, that are in progress or have been proposed, and shall include such agenda in the annual report submitted pursuant to section 1875(b) of the Social Security Act. The agenda shall be accompanied by a statement setting forth the amounts that have been obligated and expended with respect to such projects in the current and most recently completed fiscal years."

Agenda for Rural/Inner City Health Care Issues

Specific steps have been taken to establish HCFA's research agenda on rural/inner city health care issues including the following:

- HCFA held discussions with the Office of Rural Health Policy regarding potential areas of future research/demonstrations.
- HCFA also increased the emphasis on rural/inner city health care issues in its statement of funding priorities and solicitation for new projects for FY 1989.
- Through an agreement with the National Center for Health Services Research and Health Care Technology Assessment, HCFA supported a grant with the Foundation for

Health Services Research to outline and set research objectives for urban/inner-city health care issues.

- Finally, HCFA is charged with implementation of the Rural Health Care Transition Grants Program, as mandated under section 4005(e) of OBRA 87. This program is to assist small rural hospitals and their communities in the planning and implementation of projects to modify the type and extent of services such hospitals provide. Grants are expected to be awarded in FY 1989.

Obligations for Rural and Inner City Health Care Studies

Section 4403 of OBRA 87, as amended by the Medicare Catastrophic Coverage Act of 1988, mandates that HCFA set-aside 10 percent of the total obligations under HCFA's research budget for research and demonstration projects that relate substantially or exclusively to rural health care issues and 10 percent for R&D projects that relate substantially or exclusively to inner city health care issues in FYs 1988, 1989, and 1990.

Because the catastrophic coverage act was not passed until after HCFA had published its solicitation for R&D projects, HCFA was not able to focus its FY 1988 project solicitation on studies of this type. Therefore, an adequate number of proposals were not received to meet the 10 percent target for either rural or inner city studies. However, HCFA did obligate \$1 million for rural/inner-city studies in FY 1988.

Rural and Inner City Health Care Studies

Following the implementation of the Medicare hospital prospective payment system, HCFA initiated a number of projects designed to examine issues related to hospitals located in rural/inner city areas. Included among these studies were the following:

Sole Community Hospitals (Brandeis Research Center, \$64,500)—Report sent to Congress on November 27, 1987.

Uncompensated Care Costs in Large Rural Teaching Hospitals (Brandeis Research Center, \$132,000)—Results used in "Rural Teaching Hospitals and Referral Centers" report sent to Congress on February 9, 1988; also used for "Uncompensated Care" report to Congress currently being revised in HCFA.

Urban/Rural Payment Differentials under DRGs (Brandeis Research Center and Abt Associates, \$244,000)—Report sent to Congress on December 24, 1987.

Long Term Impact of PPS on Rural Hospitals (Brandeis Research Center, \$32,285)—Completed; used as theoretical basis for annual reporting as part of PPS Impact Report.

PPS Impact on Rural Hospitals (Center for Health Economics Research, \$334,000)—Continuing.

Longitudinal Studies of Local Area Hospital Use (University of Michigan, \$214,000)—Completed; no Report to Congress required.

Rural Secondary Specialty Demonstration (Lake Region Hospital (Minnesota) and Evaluation (Mathematica, \$144,164)—Continuing.

HCFA is also funding the following projects focusing primarily on health care in rural/inner city areas:

Preventive Health Services for Medicare Beneficiaries (University of Pittsburgh; projected total funding \$1,100,000)—Continuing; sites are located in rural areas.

Economy and Efficacy of Medicare Reimbursement for Preventive Services (University of North Carolina; projected total funding \$1,674,522)—Continuing; approximately one-third of sites are in rural areas.

Evaluation of National Rural Swing-Bed Program (University of Colorado; initially awarded in September 1983; project funding has been continued to respond to OBRA 87 mandate; total funding \$1,181,824)—Continuing; results used in report sent to Congress on February 5, 1988.

Medical Assistance Facility (Montana Hospital Research and Education Foundation; projected total funding \$500,000)—Continuing.

Assistance to Montana Medical Assistance Facility Demonstration Project (University of Minnesota Research Center; \$54,883)—Continuing.

Refining the Geographic Practice Cost Index: Implications for Urban and Rural Areas (The Urban Institute; projected total funding \$155,000)—Continuing.

Urban/Rural Differences in Physician Practice Patterns (Brandeis Research Center; \$52,270)—Continuing.

Health Manpower Shortage Areas (Brandeis Research Center; \$43,834)—Continuing.

HCFA's spending for rural/inner city studies totals:

FY 1983 - \$722,000

FY 1984 - \$290,000

FY 1985 - \$671,000

FY 1986 - \$651,000

FY 1987 - \$625,000

FY 1988 - \$1,000,000

In addition to these discrete projects, HCFA funds several large program evaluation efforts that focus on health care issues across settings. Included among these studies are the ongoing study of the impact of PPS on hospitals, beneficiaries, quality and access to care; and a series of studies designed to assess the issues of quality and access to care since the implementation of PPS, and to improve the methods HCFA uses to measure quality and access. These large program initiatives have, as one of their focuses, differences in health care provided in rural/urban settings.

Reports to Congress

In FY 1988, the Secretary submitted to the Congress several reports prepared by HCFA's Office of Research and Demonstrations on various mandated studies and activities. The reports were as follows:

- Clinical Social Workers [P.L. 96-499, Sec. 958].
- Impact of Outlier and Transfer Policy on Rural Hospitals [P.L. 99-272, Sec. 9113].
- Physician Payment Studies — Volume and Intensity of Physician Services [P.L. 98-21, Sec. 603(a)].
- Development of Prospective Payment Methodology for Outpatient Services [P.L. 99-509, Sec. 9343(f)].
- Study of Payment Rates for Physician Assistants [P.L. 99-509, Sec. 9338(e)].
- Social Health Maintenance Organizations [P.L. 98-369, Sec. 2355].
- Certified Registered Nurse Anesthetists [P.L. 98-369, Sec. 2312].
- Prospective Payment - Excluded Hospitals [P.L. 98-21, Sec. 603(a)(2)(C)(ii)].
- Home Health Services - Patients at Risk of Institutionalization [P.L. 97-414, Sec. 6(e)(1)(A)].
- Sole Community Hospitals [P.L. 98-21, Sec. 603(a)(30)(A)].
- Urban Rural Report [P.L. 98-21, Sec. 603(a)(2)(C)(i)].
- Hospital Specific Payment [P.L. 98-369, Sec. 2311(f)].
- Varying Proportions of Labor/Nonlabor DRG Components [P.L. 98-369, Sec. 2311(e)].
- Regional Payment Rates [P.L. 98-369, Sec. 2311(f)].
- Separate Urban and Rural Payment Rates [P.L. 98-21, Sec. 603(a)(2)(C)].

- Application of Revised Hospital Wage Index (P.L. 99-272, Sec. 9103).
- Impact of State Rate Setting Systems [P.L. 98-21, Sec. 603(a)(3)(D)].
- Swing Beds (P.L. 96-499, Sec. 904).
- Large Rural Teaching Hospitals and Rural Referral Centers [P.L. 98-21, Sec. 603(a)(3)(C)].

Chapter VI

Promoting Improvements in HCFA

Introduction

In FY 1988, HCFA had 3,815 employees working at its central office in Baltimore, Maryland, executive offices in Washington, D.C., and 10 regional offices. Their varied assignments included policy development, program operations, legislative analysis and liaison activities, health care research and demonstrations, budget preparation and analysis, actuarial studies, data collection and processing, enforcing health care quality standards, and public information activities. These activities are overseen by the Administrator, who is assisted by a deputy administrator, and associate administrators for management, operations, program development, and communications. The regional offices, which are managed by regional administrators, are located in Atlanta, Boston, Chicago, Dallas, Denver, Kansas City, New York, Philadelphia, Seattle, and San Francisco.

During the fiscal year HCFA assumed the management of six additional buildings that it occupies, revised the agency's internal control program, and intensified efforts to attract and retain highly qualified job applicants. It also

registered gains in the area of equal employment opportunity, and hired several graduate students from schools participating in the Presidential Management Intern Program.

Procurement Goals

HCFA pursued Departmental procurement preference and competition goals in the awarding of more than \$1.1 billion in contracts during FY 1988. A summary of HCFA's goals and performance in each of six procurement categories is shown in Table 9.

Internal Control Program

HCFA developed risk assessment protocols and conducted risk assessments of 86 internal control areas (ICAs) identified during the FY 1988 segmentation process. In addition, training materials were developed and extensive training was provided to ICA managers and their staffs on the internal control program and the procedures for conducting internal control reviews. Fifteen reviews were conducted in-house during the fiscal year and one was performed by an outside contractor. Six follow-

Table 9

Category	Goal	Actual	Total Dollars
1. Small Business	52.2%	45.61%	\$30,837,634
2. 8(a)	25.0%	24.25%	6,601,323
3. *Direct Minority	1.0%	74%	503,238
4. Women-owned Business	4.1%	8.77%	5,932,643
5. Labor Surplus Area	4.1%	4.70%	3,182,964
6 Competitive	80.0%	86.99%	53,627,785

* Because there is no mandated set-aside for direct awards to minority firms, achievement of this goal was primarily dependent upon the minority vendors submitting proposals for and winning competitively bid contracts.

up reviews were conducted by HCFA staff to ensure that corrective action was properly taken on adopted recommendations.

Facilities and Space Management

HCFA assumed responsibility for managing six outlying buildings under the delegation of leasing authority with the General Services Administration (GSA). The outlying buildings are near the East High Rise and East Low Rise buildings in Baltimore, which house most of the agency's central office and are maintained by the Social Security Administration under an agreement with HCFA. In another action, HCFA negotiated, through GSA, the acquisition of the Security Office Park Building at 7008 Security Boulevard, Baltimore. The 36,000 square feet of space was needed to accommodate the expansion of operations as a result of the enactment of the Medicare Catastrophic Coverage Act.

In response to the increasing attention focused on the dangers of exposure to tobacco smoke—both direct and passive—smoking was banned in all HCFA headquarters buildings as of March 15, 1988, in a move designed to safeguard the health of HCFA employees. Smoking had been permitted in designated areas prior to the ban.

Office Automation

HCFA accomplished numerous automation initiatives to increase effectiveness and improve retrieval of information. For example, the automated Comprehensive Personnel System was improved by establishing program controls to prevent input errors, updating the subsystems to reflect revised processing procedures, and by developing new program to track Employee Performance Management System (EPMS) bonuses. The agency was also involved during the fiscal year in a detailed analysis of long-range systems requirements as part of an overall systems modernization initiative.

In conjunction with the improvements to the automated systems, HCFA employees were provided with a variety of computer training

courses, including instruction in wordprocessing, and spreadsheet and database applications on personal computers. The increased use of automation has promoted efficiency in the personnel operations of the agency.

Recruiting Initiatives

In an effort to meet the increased need to recruit and retain qualified personnel, HCFA continued efforts to strengthen its recruitment programs. Several new recruitment authorities were obtained from the Office of Personnel Management, including Delegated Examining Authority and the Professional and Administrative Career Schedule B Authority. These authorities should provide managers with increased hiring flexibility and are expected to expedite the recruiting process. HCFA continued to expand its cooperative education program and focused on methods of attracting health-care curriculum graduates and minority students. At the same time, extensive negotiations were concluded with the Department of Health and Human Services regarding HCFA's proposed request for special salary rates for actuaries at the GS-5 through the GS-11 level. The request is now before OPM.

Presidential Management Intern Program

A comprehensive program was conducted by HCFA in support of the Office of Personnel Management's Presidential Management Intern Program (PMI). Twenty-one interns at HCFA were provided mentors, individual development plans, training, seminar services, and rotational assignments. The PMI program provides an excellent source for recruiting high calibre individuals with potential to assume management positions with the agency.

Promoting Health, Wellness, and Fitness Programs

In recognition of the positive impact a healthy workforce can have on employee

morale and productivity, HCFA developed an integrated approach to its health, wellness, and fitness programs. The occupational health, health benefits, Employee Assistance Program (counseling), fitness center support, health/drug abuse education, and child care referral functions were all incorporated into one organization in an effort to eliminate duplication and improve communications. A variety of health and education programs were implemented, including health screenings, (cholesterol, blood pressure, etc.), training classes for managers and supervisors, and desk-to-desk distribution of informational materials. HCFA also made efforts to improve coordination between the Employee Assistance Program and the disciplinary process. It is anticipated that this will improve supervisory sensitivity to the various personal problems faced by employees.

Equal Employment Opportunity Accomplishments

As in past years, HCFA pursued efforts in FY 1988 to assure equality in employment and promote affirmative action. The agency's workforce grew by 34 during the fiscal year to 3,815 (Table 10), and at the same time, the percentage of women and minorities in the GS/GM 13-15 grade band increased from 27.5 to 30.3 and 12.2 to 12.6, respectively. Another 0.8 percent of the GS/GM 13-15 employees were individuals with severely handicapping conditions.

Of the 17 transitional positions maintained by the agency in FY 1988, 7, or 41.2 percent, were assigned to minorities and one to a severely handicapped individual. Transitional positions are intended to prepare lower-graded staff for movement into higher positions through formal training and job experience.

Table 10

EQUAL EMPLOYMENT OPPORTUNITY ACCOMPLISHMENTS

	FY 1988	%	FY 1987	%
HCFA Workforce	3,815		3,781	
GS/GM 13-15				
Grade Band	1,575		1,525	
Minorities	199	12.6	186	12.2
Women	478	30.3	420	27.5
Severely handicapped	13	0.8	13	0.85
Transitional Positions	17		41	
Minorities	7	41.2	15	36.6
Severely handicapped	1	5.9	1	2.4

Chapter VII

Legislative Highlights

Two major pieces of legislation were enacted during FY 1988 that affected programs administered by HCFA. OBRA 87 (P.L. 100-203) was signed into law on December 22, 1987, making a series of changes largely aimed at slowing the rate of growth of expenditures in the Medicare program. The Medicare Catastrophic Coverage Act (MCCA) of 1988 (P.L. 100-360) was signed into law on July 1, 1988, representing the largest expansion of the Medicare program since its inception. The intent of MCCA is to protect the elderly and disabled from financial hardship in the event of catastrophic illness.

OBRA 87 Medicare Reimbursement and Benefit Changes

A major provision of OBRA 87 revised the Medicare payment rate for PPS hospitals for discharges occurring on or after April 1, 1988. The PPS update was 1.5 percent for hospitals in urban areas greater than 1 million, 3 percent for hospitals in rural areas, and 1 percent for other hospitals. For PPS-exempt hospitals, the FY 1988 increase was 2.7 percent (or market basket minus 2 percent). Another provision mandates a reduction beginning in FY 1989 of about 7.6 percent in a hospital's indirect medical education adjustment for each 0.1 in the ratio of interns and residents to beds. OBRA 87 also lifted the 15 percent cap on the general disproportionate share adjustment for urban hospitals with 100 or more beds, and increased the disproportionate share adjustment to 25 percent for hospitals that receive 30 percent of their revenues from State and local sources.

Other significant provisions affecting hospitals expanded the swing-bed program to include rural hospitals with fewer than 100 beds and authorized the Secretary to grant rural referral

center status to rural hospitals with 275 or more beds. Moreover, the law provided for a 7 percent reduction in payments for capital costs for the first quarter of FY 1988 and a 12 percent cut for the remainder of the fiscal year. Capital payments are to be cut by 15 percent for FY 1989 and are prohibited from being incorporated into the PPS rate before October 1, 1991.

Under OBRA 87, a sequester order mandating a 2.324 percent reduction in payments for all Part A inpatient hospital services (including capital and direct medical education) was continued through March 31, 1988, and for all other Part A services through December 31, 1987. In a related provision, payments for physicians' services are held at the 1987 level for both prevailing and customary charges during the first calendar quarter of 1988, and the 1987 maximum allowable actual charges (MAAC) for nonparticipating physicians are extended for this same quarter. The aforementioned sequester order also mandated a 2.324 percent reduction in payment for physician services through March 31, 1988.

The Medicare Economic Index (MEI) update effective April 1, 1988, for participating physicians was 3.6 percent for primary care services and 1 percent for all other physician services. For 1989 the MEI is specified at 3 percent for primary care and 1 percent for all other physician services. A bonus of 5 percent of the Medicare payment amount for physician services provided in rural underserved areas was authorized, and the prevailing charges for certain procedures identified as overpriced were reduced.

OBRA 87 further imposed a 1-year freeze on durable medical equipment (DME) payment screen limits effective January 1, 1988, and requires the Secretary to establish a fee schedule effective January 1, 1989, for each of six

categories of DME. At the same time, the limit on recognized charges for the outpatient treatment of mental disorders was increased to \$562.50 for calendar year 1988 and to \$1,375 beginning January 1, 1989. The Part B premium provision requiring that the premium produce income equal to 25 percent of the Part B program costs for the elderly was extended through calendar year 1989.

Among other major provisions of OBRA 87 were:

- Authorization for a \$15 million per-year program (FY 1989 and FY 1990) for rural demonstration projects to assist rural hospitals to plan for altered service delivery models that respond to the needs of rural America.
- Tougher quality standards that were required to be met by home health agencies in order to receive Medicare payment.
- Coverage of certified mid-wife services to the extent they are covered under State law.
- Expansion of Medicare payment for physician-assistant services in all treatment settings located in rural health manpower shortage areas.
- Authorization of direct payment of clinical psychologists practicing in rural health clinics.

Provisions were also included in OBRA 87 that affected Medicaid programs, including one that permits States to provide Medicaid for pregnant women and infants whose family income does not exceed 185 percent of the national poverty level. States were required to cover children up to age 7 who meet the income and resource requirements of the Aid to Families with Dependent Children (AFDC) program.

A second Medicaid provision established a new and separate waiver authority for home- and community-based services provided to individuals 65 and older who would otherwise require care in either a skilled nursing facility (SNF) or an intermediate care facility (ICF).

OBRA 87 added comprehensive, detailed requirements to ensure quality of life for resi-

dents in nursing homes that participate in the Medicare and Medicaid programs. In summary, the law requires that such facilities promote quality of life for the residents; develop plans of care to achieve that goal; conduct individual resident assessments to determine their physical and mental needs; provide or arrange for services that meet professional standards of quality; require a specified amount of training for nurse aides; and protect residents' rights.

MCCA of 1988

The MCCA made sweeping changes, including benefit expansions, in the Medicare program to provide protection against catastrophic illnesses. The new benefits are to be financed through a combination of a flat premium that all beneficiaries will pay (\$4 per month in 1989), and an income-related supplemental premium based on the amount of an individual's Federal tax liability (\$22.50 for each \$150 of tax liability in 1989). Some of the changes will take effect next year while others are to be phased in over a longer period of time. The following Medicare Hospital Insurance (Part A) changes are to take effect beginning January 1, 1989:

- Beneficiaries are responsible for only one Part A deductible each year.
- Beneficiaries will receive an unlimited number of days of inpatient hospital care without having to pay coinsurance. (The 190 day lifetime limit on inpatient psychiatric hospital services was retained).
- The "spell of illness" methodology is eliminated for determining the number of hospital days Medicare will cover, the skilled nursing facility coinsurance, and the Part A blood deductible.
- Medicare pays for 150 days per year of SNF care without the previous requirement for a 3-day prior hospitalization.
- Daily home health care is covered for up to 38 consecutive days.
- Hospice care is covered beyond the 210-day

limit if the beneficiary is recertified as terminally ill by a physician. The Act made the following changes in Medicare Medical Insurance (Part B):

- A limit on out-of-pocket expenses is effective beginning January 1, 1990. After a beneficiary pays \$1,370, Medicare pays 100 percent of reasonable costs or reasonable charges for any additional Part B covered services provided during the year.
- Beginning January 1, 1990, Medicare will pay for screening mammography for the detection of breast cancer, and for up to 80 hours a year of in-home respite care for a chronically dependent individual.
- Medicare coverage for outpatient prescription drugs is to be phased-in over 3 years. Beginning January 1, 1990, Medicare is to cover home intravenous drugs, including antibiotics, and other drugs that the Secretary determines can be safely administered in the home, and prescription drugs used in immunosuppressive therapy. The first year deductible is set at \$550. Beginning January 1, 1991, all other outpatient

prescription drugs are covered. The coinsurance is set at 50 percent in 1990 and 1991, 40 percent in 1992, and 20 percent in 1993 and thereafter (except for home IV drugs which is set at 20 percent).

MCCA also contained provisions affecting State Medicaid programs. One provision requires States to pay the Medicare premiums, deductibles, and coinsurance for Medicare beneficiaries with incomes up to 100 percent of the national poverty level. This is phased in over 4 years, with the qualifying income level set at 85 percent of the poverty level initially and increasing annually by 4 percentage points. States are further required by the law to extend Medicaid coverage to pregnant women and infants with incomes up to 100 percent of the national poverty level. Another provision requires State Medicaid programs to allow an individual's spouse living in the community to retain certain assets and income when the other Medicaid-eligible spouse is in an institution. The spouse living in the community would have additional financing protection not afforded under current law.

Chapter VIII

Significant Regulations Published in FY 1988

Revaluation of Assets

This proposed rule would change current regulations that are affected by section 2314 of the DEFRA (P.L. 98-369), enacted on July 18, 1984, and sections 9110 and 9509 of COBRA 85 (P.L. 99-272), enacted on April 7, 1986. These provisions amended Sections 1861 (v)(1) and 1902 (a)(13) of the Social Security Act to describe new limitations on the valuation of assets acquired as the result of changes in ownership occurring on or after July 18, 1984. These changes would affect hospitals and SNFs under the Medicare program, and hospitals, SNFs, ICFs and intermediate care facilities for the mentally retarded (ICFs/MR) under the Medicaid program. The changes are intended to promote economy in the Medicare and Medicaid programs.

Date of Publication: October 26, 1987

Periodic Interim Payments (PIP) for Hospitals and Other Providers

The final rule (with comment period) implemented section 9311(a) of OBRA 86, which set forth the circumstances under which the PIP method is available for services furnished by hospitals and other providers. With certain exceptions, inpatient hospital services furnished by prospective payment hospitals on or after July 1, 1987, are not eligible for payment on a PIP basis. However, inpatient hospital services furnished by hospitals excluded from the PIP, as well as skilled nursing services, home health services and hospice care services generally may be paid for on this basis.

Date of Publication: January 21, 1988

Standards and Conditions Covering Organ Procurement Organizations and Organ Procurement Protocols

This rule is intended to enhance the organ procurement process. It establishes a requirement for hospitals to have, as a condition of participa-

tion in the Medicare and Medicaid programs, written protocols to identify potential organ donors. It also requires that all organ transplant centers be members of and abide by the rules and requirements of the Organ Procurement and Transplantation Network. In addition, the rule sets forth requirements that an organ procurement organization must meet to be designated by Medicare for payment and to remain so designated. This includes the requirement that only one organ procurement organization can be designated per service area. The rule implements section 1138 of the Social Security Act, as added by section 9318(a) of OBRA 86.

Date of Publication: March 1, 1988

Standards and Conditions Covering Hemodialyzer Reuse

This rule established regulatory standards and conditions for safe and effective hemodialyzer reuse and reprocessing. It incorporates by reference guidelines and standards adopted by the Association for the Advancement of Medical Instrumentation plus specific Public Health Service standards. This rule assures that, where the voluntary practice of hemodialyzer reuse and reprocessing is being utilized, safe and effective reprocessing procedures are followed.

Date of Publication: October 1, 1987

Medicare As Secondary Payer

HCFA published proposed rules updating and clarifying policies dealing with Medicare as secondary payer. The regulations would incorporate statutory amendments to the Medicare secondary payer provisions, ensure identification of other payers that are primary to Medicare, ensure prompt reimbursement to Medicare of improper primary Medicare payments and incorporate changed policies dealing with workers' compensation, liability insurance, no-fault insurance and employer group health plans.

Date of Publication: June 15, 1988

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Chapter IX

Reports and Publications

Introduction

HCFA publishes a variety of reports and publications dealing with the Medicare program. Those publications listed in this chapter may be of particular interest to the Congress as well as to the public. Except where noted, single copies of the following beneficiary publications are available from local Social Security Administration offices or by written request to:

Health Care Financing Administration
Office of Public Affairs (OPA)
Room 658 East High Rise Building
6325 Security Boulevard
Baltimore, Maryland 21207

Placement on the mailing list for notification of all research and demonstration (R&D) reports as they are published, and single complimentary copies of publications, with the exception of the HCF Review, are available by written request from:

Health Care Financing Administration
Office of Research and Demonstrations (ORD)
Publications and Information
Resources Branch
Room 1-A-9 Oak Meadows Building
6325 Security Boulevard
Baltimore, Maryland 21207

What You Should Know About Medicare (ICN 460000, SSA-05-10043, January 1987). A pamphlet describing the basic aspects of Medicare, including coverage, deductibles, coinsurance and eligibility requirements.

Your Medicare Handbook (ICN 000181, HCFA-10050). A comprehensive explanation of the Medicare program for Medicare beneficiaries.

Guide to Health Insurance for People with Medicare (ICN 487790, HCFA-02110, 1987). A consumer-oriented pamphlet for Medicare beneficiaries that discusses what Medicare pays and does not pay, types of private health insurance to supplement Medicare, and what to look for when shopping for private health insurance.

Medicare and Employer Health Plans (ICN 488331, HCFA 02150, 1986). A pamphlet that explains the law that requires employers to offer employed Medicare beneficiaries age 65 or older the same health insurance plan they offer to their younger employees.

Your Hospital Stay Under Medicare's Prospective Payment System (PPS) (ICN 488334, HCFA 02150, 1986). A pamphlet describing the PPS, diagnosis related groups and Peer Review Organizations.

Hospice Benefits Under Medicare (ICN 487973, HCFA 02154, 1986). A pamphlet describing the special rules of coverage for care in a hospice program.

Beneficios de Hospicio Bajo Medicare (ICN 488332, HCFA 02162, 1986). A Spanish version of *Hospice Benefits Under Medicare*.

Thinking of Having Surgery? Think About Getting A Second Opinion (ICN 487793, HCFA 02114, 1982). A brochure addressing the advisability of seeking a second medical opinion before agreeing to any non-emergency surgery. It outlines questions a beneficiary should ask, when to get a second opinion, how to find a specialist to give a second opinion, and how to pay for a second opinion.

Medicare and You (ICN 443504, HCFA 00009, 1987). Scriptographic booklet. This booklet explains what Medicare is, what it covers and pays, and how to qualify for Medicare.

Report on Hospital Wage Index (HCFA, March 1985). This report describes the differences in wages from area to area by the labor-related portion of the Federal prospective payment rates. The report also contains the results of the HCFA wages survey and two new wage indices based on that survey. (NTIS)

Medicare and Medicaid (There is a Difference!) (ICN 443514, HCFA 0019, 1987). Scriptographic booklet. This booklet explains the difference between Medicare (an insurance program) and Medicaid (an assistance program).

Health Status of Aged Medicare Beneficiaries. This report provides descriptive information from

the National Medical Care Utilization and Expenditure Survey about selected aspects of the health status of noninstitutionalized elderly people covered by Medicare, including measures of disability, activity limitation, illness conditions, and perceived health status. (Available from ORD.)

Access to Health Care Among Aged Medicare Beneficiaries. This report provides descriptive information from the National Medical Care Utilization and Expenditure Survey about selected aspects of access to health care among noninstitutionalized elderly people covered by Medicare, including regular source of care, physical access to the regular source, insurance coverage, and the existence of medically unattended conditions. (Available from ORD.)

HCFA continued its research publications program through several series of publications that cover research and demonstration activities and statistical information on the Medicare program. These were part of a dissemination effort to reach interested user groups and to provide research results for policymakers and health professionals. The series include:

Health Care Financing Program Statistics. Provides detailed information on Medicare and Medicaid program operation and use, including data on enrollment, utilization, providers, reimbursement, and recipients.

Health Care Financing Research Reports. Reports on major intramural studies and projects conducted by HCFA. Contain significant findings that affect HCFA programs and serve as a basis for making program changes.

Health Care Financing Extramural Reports. Final reports of extramural projects funded by HCFA/ORD. Topics include hospital cost containment, long-term care reform, physician reimbursement, beneficiary access to and use of services, and health systems organizations.

National Medical Care Utilization and Expenditure Survey Reports. Reports on the survey findings, including information on access to and use of medical care, health and demographic characteristics of persons and families, and the sources and costs of services.

Health Care Financing Special Reports. Report on single themes, providing comprehensive coverage of an important issue in health care financing.

Status Report: Research and Demonstrations in Health Care Financing. Provide basic information in a brief format on the approximately 300 intramural and extramural projects conducted by HCFA/ORD to examine program expenditures as they relate to reimbursement, coverage, eligibility and management alternatives under Medicare and Medicaid.

Health Care Financing Project Reports. Include brief reports on individual research and demonstration projects that provide an overview of the project and major findings or results and include information on obtaining related publications.

Health Care Financing Review (Quarterly Journal Plus Annual Supplement). HCFA's quarterly research journal, reports findings related to health care financing and delivery. Includes trends data that highlight economic developments in the health care sector and announcements of new HCFA research publications and projects. The Review is available on a subscription basis (\$13.00 per year) from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402

Additional information on the research publications program and the availability of various reports may be obtained from the ORD Publications and Information Resources Branch, Room 1-A-9 Oak Meadows Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

Other publications and technical manuals are available for a fee by writing or phoning:

**National Technical Information
Services (NTIS)**

Document Sales

5285 Port Royal Road

Springfield, Virginia 22161

(703) 487-4650 (Document Sales)

(703) 487-5600 (General Information)

Chapter X

Report on Medicare Validation Surveys of Hospitals Accredited by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission)

Fiscal Year 1988

Introduction/Statutory Background

Section 1875 of the Social Security Act (the Act) requires the Secretary of the Department of Health and Human Services (DHHS) to continually validate the accreditation process of the Joint Commission. The purpose of the validation program is to determine whether the Joint Commission's accreditation process provides reasonable assurance that accredited hospitals comply with the Medicare conditions of participation (COPs) as deemed by section 1865 of the Act. This section also requires the Secretary of DHHS to submit an annual report to Congress on the findings of the validation effort.

Each year, HCFA selects a statistical sample from the approximately 5,200 accredited hospitals for validation surveys. Validation surveys are also conducted in response to substantial allegations of the existence of a significant deficiency or deficiencies which would, if present, adversely affect the health and safety of patients. These surveys are conducted by the Medicare State survey agencies (SAs) as authorized by section 1864(c) of the Act. During FY 1988, the SAs conducted 98 sample validation surveys and investigated 233 complaints that led to 30 full allegation surveys. This report analyzes the findings of those surveys.

Accreditation Process

The Joint Commission's accreditation survey assesses a hospital's compliance with the Joint Commission's standards. After the completion of the onsite survey, the Joint Commission makes an accreditation decision. A hospital may receive a 3-year accreditation with or without a contingency or, in cases where a hospital fails to achieve substantial overall compliance, no accreditation. A contingency stipulates that the accreditation will be withdrawn if the hospital fails to correct its deficiencies within a specified amount of time. The Joint Commission, through the use of focused onsite resurveys and/or written reports prepared by the hospital, determines whether the hospital has corrected the deficiencies necessary to retain accreditation. The contingency accreditation process is analogous to the Medicare resurvey as both assess correction of deficiencies.

The Joint Commission survey team is composed of a physician, a hospital administrator trained in the evaluation of the Life Safety Code (LSC) requirement, a nurse, and a medical technologist. The medical technologist may not always be present as the Joint Commission accepts laboratory accreditation by the College of American Pathologists (CAP). Approximately 46 percent of the Joint Commission hospitals have laboratories accredited by the CAP.

In this report period, the Joint Commission made 1,740 accreditation decisions for hospitals. Table 11 lists the types of accreditation decisions made by the Joint Commission, the number of hospitals receiving those decisions and the percentage of hospitals receiving those decisions.

The composition of the SA teams varies from State to State. Most of the States use a multidisciplinary team with representation from dietary, medical records, professional nursing, hospital administration, and laboratory science specialties. Some States have physicians who act as consultants to mem-

Table 11

JOINT COMMISSION ACCREDITATION DECISIONS

TYPE OF DECISION	NO. RECEIVING DECISION	PERCENTAGE*
3-year accreditation without contingencies	13 of 1740	0.75
3-year accreditation requiring written contingency reports	629 of 1740	36.15
3-year accreditation requiring onsite visits	41 of 1740	2.36
3-year accreditation requiring written contingency reports and onsite visits	1003 of 1740	57.64
Denial of accreditation	9 of 1740	0.52
Decisions pending further review	45 of 1740	2.5

*rounded to the nearest hundredth of a percent

Of the nine hospitals denied accreditation, five are in the appeals process, two were initial applicants and two withdrew from the Joint Commission accreditation program.

Validation and Allegation Process

1. Medicare Survey Process

The hospitals are surveyed by the SAs using the Medicare COPs for hospitals and are surveyed in the same manner as nonaccredited hospitals. In the case of a hospital selected for a sample validation survey, the SAs are requested to schedule their surveys within 60 days of the Joint Commission accreditation survey.

Instructions to the SAs require that the survey be conducted on successive days in an objective manner without reference to accreditation findings. The validation team is not furnished a copy of the accreditation report and is told not to inquire about any accreditation survey findings.

bers of the team. A few of the smaller States use generalist survey personnel only, with specialist staff available for consultation. All States use fire safety professionals (e.g., fire marshals, etc.) to determine the extent of compliance with provisions of the LSC of the National Fire Protection Association (NFPA).

The survey process uses the "deficiency" as the primary measure of hospital quality of care. There are three deficiency severity levels. The condition level is the most severe. This level indicates the facility is seriously limited in its capacity to furnish an adequate level of quality of care. Standard level deficiencies are somewhat less severe. Elements, also called factors, are the least severe. While an institution

may fail to comply with one or more of the subsidiary standards or elements during any given survey, it cannot participate in the Medicare program unless it meets each and every condition level requirement.

If an accredited hospital is found to have significant deficiencies, it is no longer deemed to meet the Medicare COPs. The hospital then becomes subject to SA surveillance under the same procedures applied to nonaccredited hospitals. Should the hospital not correct its deficiencies in accordance with an acceptable plan, the hospital would be terminated from the Medicare program. When HCFA determines that the hospital no longer has significant deficiencies, SA monitoring of the institution is discontinued, and the hospital is again deemed to meet the Medicare COPs by virtue of its accreditation.

Although the Joint Commission's requirements are comparable to the Medicare COPs, there are some differences in specific requirements. The format of the Joint Commission's standards and the survey report form they use to assess compliance are far more detailed than HCFA's.

2. Selection Basis

For sample validation surveys, HCFA selects a representative sample from the Joint Commission's schedule of hospital accreditation surveys. The random selection reflects the urban-rural mix and the range of different sizes of participating hospitals. This permits HCFA to apply the findings to the universe of accredited hospitals. In an effort to increase the validity of the analysis, the number of sample validation surveys was increased from 61 in FY 1987 to 98 in FY 1988. For FY 1989, this number was increased to approximately 200.

In addition to the sample surveys, an accredited hospital is also subject to a SA survey when there is an allegation that

significant deficiencies threaten the health and safety of patients. Based on the nature of the complaint, allegation surveys evaluate only those specified Medicare COPs as authorized by HCFA's regional offices. If the SA finds a significant deficiency in the specified condition(s), the hospital is no longer deemed to meet the Medicare COPs and is placed under SA monitoring until the deficiencies are corrected. The hospital is then subject to a full survey of all the COPs.

3. Evaluation Methodology

SA survey findings were analyzed in terms of the number and types of deficiencies found out of compliance. This report contains an analysis of the correlation between the validation and accreditation survey findings. The Joint Commission's letters of recommendation and the HCFA Statement of Deficiencies (HCFA Form - 2567) were used to identify hospital deficiencies. Strict comparability of these findings is limited because of differences in the format of standards between the Joint Commission and HCFA.

Findings of Fiscal Year 1988

1. Sample Validation Findings

During FY 1988, the SAs conducted validation surveys in 98 hospitals (Appendix A). Approximately 33 percent (32 of those 98 hospitals) failed to comply with the Medicare COPs and were placed under SA monitoring. Due to the specificity of the LSC and the laboratory requirements, this report discusses these requirements separately from other general health and safety requirements.

a. LSC

The LSC of the NFPA, a consensus standard incorporated by reference in Federal regulations, provides a reasonable level of safety from fire and other emergencies. The LSC for fire safety has been one of the most difficult requirements to meet

for both accredited and nonaccredited hospitals.

The percentage of LSC deficiencies cited in the sample validation hospitals from FY 1987 to FY 1988 remained about the same, 11 percent (7 of 61 hospitals) in FY 1987 and 13 percent (13 of 98 hospitals) in FY 1988 (Appendix B). During the FY 1988 report period, 28.1 percent (9 of the 32 hospitals failing to meet the Medicare requirements) were found out of compliance with the LSC and 1 or more COPs, and 12.5 percent (4 of the 32 hospitals failing to meet the Medicare requirements) were found out of compliance with the LSC only. For all previous report periods, 28.7 percent (156 of the 544 hospitals failing to meet Medicare requirements) were found out of compliance with the LSC and one or more COPs, and 54.8 percent (298 of the 544 hospitals failing to meet Medicare requirements) were found out of compliance with the LSC only.

The increase in LSC compliance from FY 1988 compared to all previous report periods may partially be attributed to the Joint Commission's adoption of the Fire Safety Evaluation System (FSES). The FSES was developed by the National Bureau of Standards to permit a health care facility to employ alternative measures for meeting the LSC requirements while providing an equivalent level of fire safety. The FSES is now part of the LSC.

b. General Health and Safety

The Medicare COPs are general health and safety requirements designed to assure the provision of quality of care. Short term acute care hospitals must demonstrate compliance with 19 separate COPs. The COPs may be found at 42 Code of Federal Regulations, Part 482.

For the FY 1988 report period, 28.1 percent (9 of the 32 hospitals failing to meet Medicare requirements) were found out of compliance with one or more COPs and the

LSC, and 59.4 percent (19 of the 32 hospitals failing to meet Medicare requirements) failed to comply with 1 or more COPs excluding the LSC. For all previous report periods, 28.7 percent (156 of the 544 hospitals failing to meet the Medicare requirements) were found out of compliance with 1 or more COPs and the LSC, and 16.5 percent (90 of the 544 hospitals failing to meet Medicare requirements) were found out of compliance with one or more COPs excluding the LSC (Appendix C). Overall, the percentage of sample validation hospitals found out of compliance in FY 1988 compared to all previous report periods decreased (32.6 percent versus 55.1 percent).

Of the 28 hospitals found out of compliance with the Medicare COPs dealing with general health and safety requirements, HCFA made the following determinations: 13 were out of compliance with 1 condition, 10 with 2 conditions, 2 with 3 conditions, 1 with 4 conditions, 1 with 5 conditions, and 1 with 6 conditions.

During each survey there are 263 general health and safety and 87 LSC data tags surveyed. This totals 350 data tags per survey or 34,300 data tags over the 98 sample validation surveys. For the FY 1988 sample validation surveys, there were a total of 54 conditions, 262 standards, and 903 elements found out of compliance. On average, 0.55 conditions, 2.67 standards, and 9.21 elements were out of compliance per sample validation hospital (Appendix D).

For FY 1988, the 3 Medicare COPs found out of compliance most frequently were laboratory services (13 percent), physical environment due to LSC deficiencies (9 percent), and quality assurance (9 percent). All 3 Medicare COPs have remained problems for the past several years. Quality assurance was the most frequent condition found out of compliance (15 percent in the FY 1987 validation surveys (Appendix B).

c. Laboratory Deficiencies

The Joint Commission accepts laboratory accreditation by the CAP in lieu of its own survey in about 46 percent of its hospitals. The remaining 54 percent are surveyed as part of the Joint Commission accreditation process. At this time, however, HCFA does not have access to the CAP findings.

Of the 98 sample validation surveys conducted in FY 1988, there were 13 hospitals in which the SAs found non-compliance with the requirements for laboratories. In these hospitals, the Joint Commission surveyors had documented findings in the same areas, but not in the same quantity or severity. The deficiencies identified by the Joint Commission included a lack of adequate procedures, failure to follow procedure, and failure to maintain adequate records. The most common problem cited by the SAs was failure to include the proper number of standards or controls at the proper frequency for each laboratory procedure.

2. Allegation Survey Findings

During FY 1988, there were 233 allegation surveys conducted. Allegation surveys are usually conducted in areas that deal directly with patient care rather than in the laboratory services COPs or the LSC. This is because most of the complaints are filed by patients and/or their relatives, and the complaints usually concern patient care rather than laboratory or facility structure. Two hundred and three (86 percent) were found in compliance with Medicare requirements, and 30 (13 percent) were determined to have deficiencies of sufficient severity to place them under SA surveillance (Appendix E). Therefore, the SAs conducted full surveys stemming from complaint investigations in only 30 hospitals since full surveys are performed only in hospitals where a complaint investigation reveals 1 or more surveyed conditions as being not met.

From FY 1987 to FY 1988, the percentage of hospitals found out of compliance with the Medicare COPs and LSC increased slightly (13 percent versus 9 percent). Ninety-six percent (29 of 30 hospitals) were found out of compliance with the Medicare COPs excluding the LSC, 3 percent (1 of 30 hospitals) were found out of compliance with the LSC only, and 6 percent (2 of 30 hospitals) were found out of compliance with at least 1 Medicare COP and the LSC (Appendix F). Results of investigations into allegations showed that in the 30 hospitals placed under SA surveillance, the most frequently occurring deficient condition was quality assurance (50 percent) (Appendix G).

Comparison of Joint Commission and Validation Survey Findings

1. LSC

The total number of LSC deficiencies cited by the SA surveyors in the 98 sample validation hospitals was 597. The Joint Commission surveyors cited 211 total deficiencies. Comparison reveals that the SA surveyors found 3 times more LSC deficiencies in FY 1988 sample validation hospitals than the Joint Commission surveyors. In five sample validation hospitals found out of compliance with the LSC by the SA surveyors, the Joint Commission surveyors did not find any LSC deficiencies. In the remaining hospital, many of the deficiencies cited by the Joint Commission surveyors were for lack of documentation rather than for actual operation of a device or a fire protection feature. This was most notable with respect to fire alarm systems. The Joint Commission citations were for "lack of documentation" that a fire alarm system was tested monthly, while the SA citations were for lack of electrical supervision or lack of an emergency power supply for the alarm system.

Both the Joint Commission and SA surveyors are required to survey for documentation to see whether fire drills are held at appropriate intervals (quarterly on each shift). SA surveyors often require the hospital to conduct a fire drill for their observation. HCFA can not determine from a review of the survey forms whether the Joint Commission surveyors routinely observe a fire drill as a measure to evaluate the effectiveness of the fire drill procedures of each hospital. The Joint Commission surveyors only document whether fire drills were held a sufficient number of times.

Only 68 percent (67 of 98 sample validation hospitals) had comparable findings between the SA and the Joint Commission surveys for LSC deficiencies. The remaining 31 sample validation hospitals had notable differences in LSC surveys. The SA surveyors documented a pattern of deficiencies in the following areas: missing sprinkler heads, lack of wire glass vision panels, non-labeling of gas cylinders, and non-combustible waste basket deficiencies. These deficiency patterns were not documented as findings by the Joint Commission surveyors. There were seven sample validation hospitals in which the SA surveyors found no LSC deficiencies but the Joint Commission surveyors did find LSC deficiencies. In these seven hospitals, the only notable pattern of deficiencies was corridor wall items such as unwired glass or walls that did not extend to the roof or to the bottom of the floor.

2. General Health and Safety Requirements

The Joint Commission and SA surveyors generally cite the same broad categories of deficiencies; however, specific problems and their approach to correcting those problems differ. This was most notable in the citations on quality assurance. The Joint Commission surveyors frequently cited problems in how written quality assurance plans address monitoring and evaluation processes by stating "specific reference is made to lack of documenta-

tion." The Joint Commission surveyors may then provide consultation to assist the hospital in correcting its deficiencies. The SA surveyors, however, cited problems in quality assurance related to how corrective action and follow-up is implemented after a quality assurance problem is actually identified. The SA surveyors do not provide consultation.

There were some differences in the number and severity of deficiencies cited by the two organizations. The SAs found 14 percent (14 of 98 sample validation hospitals) with 1 or more COPs out of compliance without comparable severity findings by the Joint Commission. Half of these noncomparable surveys were in general health and safety conditions and half were in the LSC and the laboratory services condition. In addition, 16 percent (16 of 98 sample validation hospitals) had general health and safety standards and elements out of compliance without comparable findings by the Joint Commission. Generally, out of the 98 sample validation surveys for FY 1988, quality assurance problems were cited in greater detail and more frequently by the Joint Commission surveyors than by the SA surveyors. This may be due to the longer and more detailed survey report form used by the Joint Commission and the Joint Commission's consultative role.

3. Laboratory

Joint Commission and SA surveyors generally cited laboratories for similar deficiencies, but based on comparative data, the Joint Commission has not been as thorough in documenting specific findings or as willing to judge the severity of deficiencies sufficient to warrant a repeat survey. Specifically, the SA surveyors frequently cite quality control problems and proficiency testing problems in laboratories and considered these problems as having a greater severity level than did the Joint Commission surveyors.

Of the 13 hospitals found by the SAs to have laboratory condition level deficiencies, there was complete agreement between the SA and Joint Commission on only 1 survey. Without the CAP data, HCFA was unable to perform a comparative analysis of 35 of the 98 hospital (36 percent) surveys in the laboratory services condition for FY 1988. By eliminating the CAP-accredited laboratories from this analysis, the comparison of the Joint Commission findings with SA findings was reduced to 63 hospitals.

The Joint Commission has moved in a positive direction by seeking out satellite laboratories and including them in their inspections. Numerous citations were noted in satellite facilities that perform arterial blood gas analysis. HCFA is concerned about alternate testing locations for other "simple" laboratory tests such as glucose monitoring, urinalysis, and occult blood. For example, the SAs cited some facilities for deficiencies related to glucose testing in hospital wards. These deficiencies ranged from failure to provide training to the personnel performing the test and absence of quality control performance to a total lack of documentation of calibration and quality control checks. There were no citations by the Joint Commission surveyors for tests performed in similar settings.

Comparison of FY 1988 Sample Validation Surveys and FY 1988 Surveys of Nonaccredited Hospitals

Generally, the SAs noted the same pattern of deficiencies between the FY 1988 sample validation hospitals and the findings in the universe of nonaccredited hospitals for FY 1988.

1. Life Safety Code (LSC)

The average number of LSC deficiencies cited per FY 1988 sample validation hospital was greater than the average number of

deficiencies per FY 1988 nonaccredited hospital (6.77 compared to 3.66). Although the average number of deficiencies cited by the SA surveyors increased, the pattern of deficiencies remained consistent.

2. General Health and Safety Requirements

The 3 general health and safety requirements found out of compliance most frequently for the 98 FY 1988 sample validation hospitals were laboratory services (13 percent), physical environment due to the LSC (9 percent), and quality assurance (9 percent). The 3 requirements out of compliance most frequently for the universe of FY 1988 nonaccredited hospitals were quality assurance (8 percent), infection control (5 percent, and governing body (5 percent). Following these were deficiencies in laboratory services (4 percent) and physical environment (3 percent) (Appendix H).

There were approximately the same number of conditions out of compliance per sample validation hospital as in the universe of nonaccredited hospitals, 0.55 compared to 0.56. However, the sample validation hospitals had a smaller number of standards and elements out of compliance. The average number of standards out of compliance per sample validation hospital was 2.67 and the average number of elements out of compliance was 9.21. The average number of standards out of compliance per nonaccredited hospital was 3.48 and the average number of elements out of compliance was 11.98.

3. Laboratory Services

Laboratory services condition level deficiencies were cited in a larger percentage of sample validation hospitals than in the universe of nonaccredited hospitals for FY 1988, 13 percent compared to 4 percent.

Conclusions

This report shows a slight decrease in the percentage of sample validation hospitals found out of compliance with one or more conditions of participation when compared to all previous report periods. For FY 1988 allegation surveys, the percentage of hospitals found out of compliance is slightly higher than that found in FY 1987.

1. Validation Surveys

The FY 1988 sample validation hospitals had close to the same number of condition level deficiencies per hospital as in FY 1987. Quality assurance condition level deficiencies still ranked among the top three unmet Medicare COPs as in the FY 1987 report period. Although the Joint Commission's requirements are comparable to the Medicare COPs, there are some differences.

The format of the Joint Commission's standards and the survey report form used to assess compliance are far more detailed. The greater detail may be due to the Joint Commission's consultative role. Also, the differences between the SA and the Joint Commission's survey teams may result in varied areas of interest, focus, and expertise. Strict comparability of findings between SA and Joint Commission survey report forms was limited due to the differences in the format of standards between HCFA and the Joint Commission.

For the LSC, strict paper review of the Joint Commission's survey report forms showed the Joint Commission surveyors cited hospitals for lack of documentation rather than for problems with actual operation of fire protection features.

For general health and safety requirements, the Joint Commission surveyors did not cite deficiencies at the same severity level to count a condition out of compliance as did the SA surveyors. For the laboratory requirements, the Joint Commission survey-

ors did not document the same quantity or severity of problems as the SA surveyors.

Seven (7) of the 19 COPs for hospitals are optional services. For this reason, SA surveyors do not check for compliance in all COPs in each hospital since all hospitals do not offer every optional service. Therefore, in the 98 sample validation hospitals, the SA surveyors looked for compliance in a total of approximately 1800 Medicare COPs.

In the 14 hospitals having a total of 18 condition level deficiencies with no comparable findings by the Joint Commission, a concurrence index was applied to put this number of deficiencies in perspective. The concurrence index was determined by subtracting the deficient 18 COPs from the universe of 1,800 conditions surveyed in the 98 sample validation hospitals.

This number (1,782) was then divided by 1,800. The result is 99 percent, meaning that HCFA findings were comparable with the Joint Commission findings 99 percent of the time. While composition of survey teams and the format of standards differ, the concurrence index shows that both programs assure comparable findings.

2. Allegation Surveys

The data shows an increase in the percentage of hospitals found to have 1 or more conditions out of compliance as a result of allegation investigations.

Of the 30 hospitals surveyed as the result of substantial allegations, 13 were not in compliance with 1 or more conditions of participation as compared to 9 percent from the last report period. However, over all previous report periods combined, the percentage of complaints substantiated remained relatively constant.

Recommendations

There is a problem with strict paper review in validating the Joint Commission's accredita-

tion process. HCFA is unable to determine the nature of the deficiencies based on how they are written. HCFA suggests that observation surveys of the Joint Commission accreditation process be conducted to better assess how the Joint Commission evaluates facilities for compliance with the LSC and all the Medicare COPs dealing with general health and safety

requirements. Observation of the Joint Commission's surveyor training programs would also give HCFA insight into the Joint Commission's accreditation process. In the area of laboratory services, it would be valuable if HCFA had access to the CAP findings that the Joint Commission receives.

APPENDIX A

FY 1988 SAMPLE VALIDATION SURVEYS JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS 98 HOSPITALS

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
<u>REGION I</u>				
20-0013 Waldo County General Belfast, Maine	49	3 - year accreditation	met*	—
07-4005 Norwich Hospital Norwich, Connecticut	649	3 - year accreditation	met	—
07-4006 Fairfield Hills Hospital Newtown, Connecticut	220	3 - year accreditation	met	—
22-2041 Springfield Municipal Springfield, Maine	438	3 - year accreditation	met	—
<u>REGION II</u>				
33-0235 Auburn Memorial Auburn, New York	266	3 - year accreditation	met	—
31-3029 Garden State Rehab Toms River, New Jersey	60	3 - year accreditation	not met**	FD, PE-LSC
31-0112 Bayshore Community Holmdel, New Jersey	218	3 - year accreditation	met	—
33-0022 Mohawk Valley General Ilion, New York	66	3 - year accreditation	not met	Q, N, I
33-0244 St. Francis Hospital Buffalo, New York	60	3 - year accreditation	met	—
33-0242 Victoria Memorial Brooklyn, New York	254	3 - year accreditation	not met	G, Q, N, MR, FD, PE-LSC

* "Met" indicates that the hospital met all Conditions. Standard and element level deficiencies may have been found.

** "Not Met" indicates that the hospital was out of compliance with one or more Conditions.

Letter Code for Conditions Out of Compliance

F - Federal, State, and local laws	L - Laboratory Services	A - Anesthesia Services
G - Governing Body	PE - Physical Environment	NM - Nuclear Medicine
Q - Quality Assurance	MR - Medical Record Services	O - Outpatient Services
M - Medical Staff	FD - Food and Dietetic Services	E - Emergency Services
N - Nursing Services	I - Infection Control	RS - Rehabilitation Services
P - Pharmaceutical Services	S - Surgical Services	RC - Respiratory Care
R - Radiologic Services	LSC - Life Safety Code	

APPENDIX A (Continued)

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
31-0093 Columbus Hospital Newark, New Jersey	206	3 - year accreditation	met	—
<u>REGION III</u>				
08-0002 Milford Memorial Milford, Delaware	185	3 - year accreditation	met	—
21-0037 Memorial Hospital-Easton Easton, Maryland	183	3 - year accreditation	met	—
51-0046 Princeton Community Princeton, West Virginia	211	3 - year accreditation	met	—
21-0027 Sacred Heart Cumberland, Maryland	240	3 - year accreditation	met	—
39-4002 Haverford State Haverford, Pennsylvania	153	3 - year accreditation	not met	LSC
49-3301 Children's Hospital Norfolk, Virginia	144	3 - year accreditation	met	—
49-4010 Northern VA Mental Health Falls Church, Virginia	114	3 - year accreditation	met	—
39-0090 Western Pennsylvania Hospital Pittsburg, Pennsylvania	395	3 - year accreditation	not met	PE-LSC
21-4002 Eastern Shore Hospital Cambridge, Maryland	450	3 - year accreditation	not met	Q
39-0024 Wills Eye Hospital Philadelphia, Pennsylvania	120	3 - year accreditation	not met	PE-LSC
39-0220 Southern Chester County West Grove, Pennsylvania	69	3 - year accreditation	met	—

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APPENDIX A (Continued)

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
<u>REGION IV</u>				
10-0060 Miami Heart Institute Miami, Florida	258	3 - year accreditation	met	—
18-0054 Caldwell County Hospital Princeton, Kentucky	50	3 - year accreditation	not met	Q, L
34-0025 Haywood County Hospital Clyde, North Carolina	200	3 - year accreditation	not met	L, RC
10-0042 Doctor's Hospital Hollywood, Florida	124	3 - year accreditation	not met	I
10-0052 Winter Haven Hospital Winter Haven, Florida	605	3 - year accreditation	met	—
11-0016 West GA Medical Center LaGrange, Georgia	276	3 - year accreditation	met	—
18-0064 Mary Chiles Hospital Mt. Sterling, Kentucky	63	3 - year accreditation	not met	Q, L
01-0022 Baptist Medical Center Centre, Alabama	60	3 - year accreditation	met	—
42-0030 Colleton Regional Hospital Waterboro, South Carolina	135	3 - year accreditation	met	—
34-0111 Chatham Hospital Siler City, North Carolina	49	3 - year accreditation	met	—
44-4003 Ridgeview Psych Hospital Oak Ridge, Tennessee	44	3 - year accreditation	met	—
10-0131 Humana Bisqayne Miami, Florida	458	3 - year accreditation	not met	PE-LSC

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P - Pharmaceutical Services	S - Surgical Services	RC - Respiratory Care
R - Radiologic Services	LSC - Life Safety Code	

APPENDIX A (Continued)

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
10-0217 Humana Sebastian Sebastian, Florida	133	3 - year accreditation	met	—
11-0156 Effingham County Hospital Springfield, Georgia	45	3 - year accreditation	not met	L
11-0041 Habersham County Hospital Demorest, Georgia	59	3 - year accreditation	met	—
18-0123 Humana Suburban Louisville, Kentucky	376	3 - year accreditation	not met	PE-LSC, L
34-0088 Transylvania Community Brvard, North Carolina	104	3 - year accreditation	not met	RC, L
42-0019 Chester County Hospital Chester, South Carolina	119	3 - year accreditation	not met	Q, L
44-0016 Baptist Memorial Hospital Huntington, Tennessee	70	3 - year accreditation	met	—
44-0064 South Pittsburg Municipal South Pittsburg, Tennessee	107	3 - year accreditation	met	—
44-4013 Cumberland Memorial Nashville, Tennessee	20	3 - year accreditation	met	—
42-0011 Cannon Memorial Hospital Pickens, South Carolina	56	3 - year accreditation	not met	L
01-0152 Knollwood Park Mobile, Alabama	315	3 - year accreditation	met	—
01-0033 Univ. of Alabama Hospital Birmingham, Alabama	863	3 - year accreditation	not met	PE-LSC

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N - Nursing Services	I - Infection Control	RS - Rehabilitation Services
P - Pharmaceutical Services	S - Surgical Services	RC - Respiratory Care
R - Radiologic Services	LSC - Life Safety Code	

APPENDIX A (Continued)

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
<u>REGION V</u>				
14-0122 Hinsdale Hospital Hinsdale, Illinois	456	3 - year accreditation	met	—
23-0069 McPherson Community Howell, Michigan	136	3 - year accreditation	met	—
36-0083 St. John Medical Center Steubenville, Ohio	258	3 - year accreditation	met	—
14-0143 St. Margaret's Hospital Spring Valley, Illinois	188	3 - year accreditation	not met	L, PE-LSC
15-0113 Community Hospital Anderson, Indiana	207	3 - year accreditation	met	—
36-0068 Toledo Hospital Toledo, Ohio	741	3 - year accreditation	met	—
36-0175 Clinton Memorial Hospital Wilmington, Ohio	143	3 - year accreditation	met	—
14-0019 Shelby Memorial Hospital Shelbyville, Illinois	73	3 - year accreditation	met	—
15-0006 La Porte Hospital La Porte, Indiana	227	3 - year accreditation	met	—
24-0017 St. Mary's Hospital Detroit Lakes, Minnesota	87	3 - year accreditation	met	—
36-0069 Fulton County Health Center Wauseon, Ohio	119	3 - year accreditation	met	—

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APPENDIX A (Continued)

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
52-0002 St. Michael's Hospital Stevens Point, Wisconsin	181	3 - year accreditation	not met	LSC
52-0139 West Allis Memorial West Allis, Wisconsin	350	3 - year accreditation	met	—
23-0060 West Shore Hospital Manistee, Michigan	95	3 - year accreditation	met	—
<u>REGION VI</u>				
04-0126 Baptist Memorial Hospital Hardy, Arkansas	40	3 - year accreditation	met	—
32-0033 Los Alamos Medical Center Los Alamos, New Mexico	85	3 - year accreditation	met	—
45-0065 Sweeny Community Hospital Sweeny, Texas	49	3 - year accreditation	not met	Q, I, E, L
37-0184 City of Faith Hospital Tulsa, Oklahoma	294	3 - year accreditation	met	—
37-0076 Mission Hill Memorial Shawnee, Oklahoma	78	3 - year accreditation	met	—
37-0089 Tahlequah City Hospital Tahlequah, Oklahoma	99	3 - year accreditation	met	—
45-0016 McAllen Medical Center McAllen, Texas	295	3 - year accreditation	not met	I
45-0110 South Park Medical Center Lubbock, Texas	94	3 - year accreditation	not met	P, E, RC, A, L
19-3300 Children's Hospital New Orleans, Louisiana	153	3 - year accreditation	met	—

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APPENDIX A (Continued)

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
37-0139 Perry Memorial Hospital Perry, Oklahoma	28	3 - year accreditation	met	—
45-4035 University Park Hospital Tyler, Texas	80	3 - year accreditation	met	—
37-0012 Pawhuska Hospital Pawhuska, Oklahoma	33	3 - year accreditation	met	—
45-0315 Garland Community Hospital Garland, Texas	128	3 - year accreditation	met	—
19-0090 Humana Hospital-Winn Parish Winnfield, Louisiana	103	3 - year accreditation	not met	Q, L, FD
45-0712 Starlite Valley Hospital Centerpoint, Texas	42	3 - year accreditation	not met	I, E
<u>REGION VII</u>				
26-0108 Missouri Baptist Hospital Town and Country, Missouri	494	3 - year accreditation	met	LSC
17-4006 Lamed State Hospital Lamed, Kansas	82	3 - year accreditation	met	—
26-0034 Bates County Memorial Butler, Missouri	53	3 - year accreditation	not met	G, Q
28-0060 Archbishop Mercy Lincoln, Nebraska	470	3 - year accreditation	met	—
17-0016 St. Francis Hospital Topeka, Kansas	378	3 - year accreditation	met	—
26-4019 Care Unit Hospital St. Louis, Missouri	140	3 - year accreditation	not met	N

Letter Code for Conditions Out of Compliance

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APPENDIX A (Continued)

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
26-0190 Lee's Summit Community Lee's Summit, Missouri	114	3 - year accreditation	met	—
<u>REGION VIII</u>				
27-0041 Powell County Hospital Deer Lodge, Montana	19	3 - year accreditation	not met	L
46-0039 Bear River Valley Hospital Tremonton, Utah	20	3 - year accreditation	met	—
06-0060 Conejos County Hospital LaJara, Colorado	15	3 - year accreditation	met	—
27-0058 Northern Montana Hospital Havre, Montana	98	3 - year accreditation	not met	PE-LSC
<u>REGION IX</u>				
05-0153 O'Connor Hospital San Jose, California	398	3 - year accreditation	met	—
03-0012 Yauapai Regional Medical Center Prescott, Arizona	129	3 - year accreditation	met	—
05-0168 St. Jude Hospital Fullerton, California	304	3 - year accreditation	met	—
05-0530 Midwood Community Hospital Stanton, California	110	3 - year accreditation	met	—
05-0021 Woodruff Community Hospital Long Beach, California	99	3 - year accreditation	not met	LSC
05-0613 St. Catherine Hospital Moss Beach, California	123	3 - year accreditation	met	—

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APPENDIX A (Continued)

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
05-4012 Mesa Vista Hospital San Diego, California	150	3 - year accreditation	met	—
29-4004 HCA Montevista Hospital Las Vegas, Nevada	80	3 - year accreditation	met	—
REGION X				
38-0027 Mercy Medical Center Roseburg, Oregon	111	3 - year accreditation	met	—
02-0012 Fairbanks Memorial Hospital Fairbanks, Alaska	177	3 - year accreditation	met	—
38-0029 Silverton Hospital Silverton, Oregon	38	3 - year accreditation	met	—
50-0404 ** Eastern State Hospital Medical Lake, Washington	392	3 - year accreditation	not met	N

** Joint Commission findings not finalized by the time necessary for analysis in this report, so SA findings were not compared to Joint Commission findings for this facility.

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APPENDIX B

SAMPLE VALIDATION SURVEYS FREQUENCY OF UNMET MEDICARE CONDITIONS IN HOSPITALS FY 1987 AND FY 1988

CONDITION OF PARTICIPATION	FY 1987 (n = 61)		FY 1988 (n = 98)	
	Frequency	Percent	Frequency	Percent
Compliance with Federal, State and Local Laws 482.11	4	7	0	0
Governing Body 482.12	4	7	2	2
Quality Assurance 482.21	9	15	9	9
Medical Staff 482.22	3	5	0	0
Nursing Services. 482.23	4	7	4	4
Medical Record Services 482.24	5	8	1	1
Pharmaceutical Services. 482.25	3	5	1	1
Radiologic Services 482.26	1	2	0	0
Laboratory Services 482.27	4	7	13	13
Food and Dietetic Services.....482.28	3	5	3	3
Physical Environment 482.41	1	2	9	9
Infection Control. 482.42	8	13	5	5
Surgical Services 482.51	3	5	0	0
Anesthesia Services 482.52	1	2	1	1
Nuclear Medicine Services 482.53	0	0	0	0
Outpatient Services. 482.54	1	2	0	0
Emergency Services 482.55	1	2	3	3
Rehabilitation Services 482.56	1	2	0	0
Respiratory Care Services 482.57	0	0	3	3
*Life Safety Code 482.57	7	11	13	13

*The requirement that a hospital be in compliance with the provisions of the Life Safety Code (LSC) is contained in Condition of Participation 482.41 - Physical Environment. For purposes of this report, however, LSC is reported separately because it is a separate survey process.

APPENDIX C

SAMPLE VALIDATION SURVEYS - VALIDATION DECISIONS BY SURVEY PERIOD

VALIDATION SURVEY DECISIONS	FY 1988		FY 1987		ALL PREVIOUS REPORT PERIODS (INCLUDING FY 1987)	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Hospitals in compliance	66	67.4	40	66	444	44.9
Hospitals out of compliance	32	32.6	21	34	544	55.1
Surveys performed	98	100.0	61	100	988	100.0
REASONS FOR NONCOMPLIANCE	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Hospitals out of compliance with Life Safety Code only	4	12.5	7	33.3	298	54.8
Hospitals out of compliance with Life Safety Code and at least one Condition of Participation	9	28.1	2	9.5	156	28.7
Hospitals out of compliance for reasons other than Life Safety Code	19	59.4	12	57.2	90	16.5
TOTAL	32	100	21	100	544	100

LSC - Life Safety Code

APPENDIX D

FISCAL YEAR 1988 VALIDATION SURVEYS OF ACCREDITED HOSPITALS (n = 98)

Number of Conditions	Number of Standards	Number of Elements	Number of Life Society Code	Conditions per Hospital	Standards per Hospital	Elements per Hospital	Life Safety Code per Hospital
54	262	903	664	0.55	2.67	9.21	6.77

FISCAL YEAR 1988 SURVEYS OF NONACCREDITED HOSPITALS (n = 1395)

Number of Conditions	Number of Standards	Number of Elements	Number of Life Society Code	Conditions per Hospital	Standards per Hospital	Elements per Hospital	Life Safety Code per Hospital
782	4851	16701	5105	0.56	3.48	11.98	3.66

APPENDIX E

ALLEGATION INVESTIGATION SURVEYS HOSPITALS PLACED UNDER STATE AGENCY SURVEILLANCE 32 HOSPITALS

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	MEDICARE CONDITIONS NOT MET
<u>REGION I</u>					
22-4017 Dr. Harry Solomon Lowell, Massachusetts	46	12/07/87	*	*	PE
22-0036 St. Elizabeth Hospital Brighton, Massachusetts	306	9/13/88	*	*	PE
22-0120 Hahnemann Hospital Boston, Massachusetts	56	5/27/88	8/31/88	*	Q
22-0068 Central Hospital Somerville, Massachusetts	92	9/28/88	*	*	Q
22-2018 Cushing Hospital Framingham, Massachusetts	270	7/28/88	8/31/88	*	Q
<u>REGION II</u>					
33-0316 Westchester Square Hospital Bronx, New York	205	11/5-6/87	2/19/88	*	Q
33-0167 Nassau County Medical Center East Meadow, New York	615	6/28/88	8/24/88	*	G, Q, FD, PE, N
<u>REGION III</u>					
None					
<u>REGION IV</u>					
25-0048 St. Dominics Hospital Jackson, Mississippi	409	9/13/88	*	*	LSC

Letter Code for Conditions Out of Compliance

F - Federal, State, and local laws	L - Laboratory Services	A - Anesthesia Services
G - Governing Body	PE - Physical Environment	NM - Nuclear Medicine
Q - Quality Assurance	MR - Medical Record Services	O - Outpatient Services
M - Medical Staff	FD - Food and Dietetic Services	E - Emergency Services
N - Nursing Services	I - Infection Control	RS - Rehabilitation Services
P - Pharmaceutical Services	S - Surgical Services	RC - Respiratory Care
R - Radiologic Services	LSC - Life Safety Code	

APPENDIX E (Continued)

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	MEDICARE CONDITIONS NOT MET
44-0151 Riverpark Hospital McMinnville, Tennessee	89	7/12/88	9/16/88	*	MR
34-0025 Haywood County Hospital Clyde, North Carolina	200	7/14/88	9/12/88	*	L, RC
34-0088 Transylvania Community Hospital Brvard, North Carolina	104	7/12/88	9/12/88	*	L, RC
42-0039 Wallace Thompson Hospital Union, South Carolina	143	12/11/87	1/12/88	*	G, Q, PE, I
<u>REGION V</u>					
23-0104 Harper Hospital Detroit, Michigan	858	5/12/88	7/28/88	*	G, N, FD, RC
14-2006 Sycamor Hospital Sycamor, Illinois	49	6/02/88	9/12/88	*	G, Q, M, N, P, I
<u>REGION VI</u>					
45-0148 Walls Regional Hospital Cleburne, Texas	112	8/30/88	*	*	MR
19-0090 Humana Hospital-Winn Parish Winnfield, Louisiana	103	5/27/88	*	*	Q, L, FD
45-0096 St. Mary's Hospital Port Arthur, Texas	278	7/26/88	8/29/88	*	P, A
45-2010 Baptist Geriatric Hospital San Angelo, Texas	118	5/5-6/88	6/01/88	*	N
45-0087 HCA North Hills Medical Center North Richland Hills, Texas	160	9/28/88	*	*	E

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R - Radiologic Services	LSC - Life Safety Code	

APPENDIX E (Continued)

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	MEDICARE CONDITIONS NOT MET
45-0587 Brownwood Regional Hospital Brownwood, Texas	218	5/3-4/88	6/13/88	*	Q, FD, I, A
45-0184 Southwest Memorial Hospital Houston, Texas	887	8/04/88	9/15/88	*	P
<u>REGION VII</u>					
26-0044 Hedrick Medical Center Chillicothe, Missouri	80	5/12/88	6/15/88	*	Q, M, N
28-0003 Bryan Memorial Hospital Lincoln, Nebraska	344	8/31/88	*	*	Q
26-0034 Bates County Memorial Butler, Missouri	53	8/31/88	*	*	G, Q
<u>REGION VIII</u>					
None					
<u>REGION IX</u>					
05-0161 Medical Center of LaMirada LaMirada, California	141	9/27-28/88	*	*	G, Q, M, LSC
05-0276 Merrithew Memorial Martinez, California	311	6/14-17/88	8/25/88	*	PE
05-0243 Desert Hospital Palm Springs, California	350	6/03/88	*	*	Q
05-0063 Hollywood Presbyterian Los Angeles, California	57	9/07-09/88	*	*	G, Q, LSC
<u>REGION X</u>					
None					

Letter Code for Conditions Out of Compliance

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M - Medical Staff	FD - Food and Dietetic Services	E - Emergency Services
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APPENDIX F

ALLEGATION INVESTIGATION SURVEYS COMPLIANCE AND NONCOMPLIANCE DECISIONS

ALLEGATION INVESTIGATION SURVEY DECISIONS	FY 1988		FY 1987	
	NUMBER	PERCENT	NUMBER	PERCENT
Hospitals in compliance	203	86	552	91
Hospitals out of compliance	32	14	54	9
Surveys performed	235	100	606	100
REASONS FOR NONCOMPLIANCE	NUMBER	PERCENT	NUMBER	PERCENT
Hospitals out of compliance with Life Safety Code only	1	3	*	*
Hospitals out of compliance with Life Safety Code and at least one Condition of Participation	2	6		
Hospitals out of compliance for reasons other than Life Safety Code	29	91		
TOTAL	32	100		

*Information not available for comparison.

APPENDIX G

ALLEGATION INVESTIGATIONS FREQUENCY OF UNMET MEDICARE CONDITIONS IN HOSPITALS PLACED UNDER STATE AGENCY SURVEILLANCE FY 1988 (n = 32)

CONDITION OF PARTICIPATION	NUMBER	PERCENT
Compliance with Federal, State and Local Laws. 482.11	0	0
Governing Body 482.12	7	22
Quality Assurance. 482.21	16	50
Medical Staff 482.22	3	9
Nursing Services 482.23	6	19
Medical Record Services. 482.24	2	6
Pharmaceutical Services 482.25	5	16
Radiologic Services 482.26	0	0
Laboratory Services 482.27	3	9
Food and Dietetic Services 482.28	5	16
Physical Environment. 482.41	6	19
Infection Control. 482.42	4	12
Surgical Services 482.51	0	0
Anesthesia Services 482.52	4	12
Nuclear Medicine Services 482.53	0	0
Outpatient Services 482.54	0	0
Emergency Services. 482.55	1	3
Rehabilitation Services. 482.56	0	0
Respiratory Care Services 482.57	3	9
Life Safety Code 482.57	3	9

*The requirement that a hospital be in compliance with the provisions of the Life Safety Code (LSC) is contained in Condition of Participation 482.41 - Physical Environment. For purposes of this report, however, LSC is reported separately because it is a separate survey process.

APPENDIX H

JOINT COMMISSION ACCREDITED HOSPITAL VALIDATION AND NONACCREDITED HOSPITAL SURVEYS FREQUENCY OF UNMET MEDICARE CONDITIONS (Except Life Safety Code)

CONDITION OF PARTICIPATION	Nonaccredited Universe FY 1988 (n = 1395)		Sample Validation FY 1988 (n = 98)	
	Frequency	Percent	Frequency	Percent
Compliance with Federal, State and Local Laws 482.11	40	2	0	0
Governing Body 482.12	77	5	2	2
Quality Assurance 482.21	115	8	9	9
Medical Staff 482.22	55	3	0	0
Nursing Services 482.23	56	4	4	4
Medical Record Services 482.24	28	2	1	1
Pharmaceutical Services 482.25	50	3	1	1
Radiologic Services 482.26	11	1	0	0
Laboratory Services 482.27	65	4	13	13
Food and Dietetic Services 482.28	25	1	3	3
Physical Environment 482.41	44	3	9	9
Infection Control 482.42	78	5	5	5
Surgical Services 482.51	21	1	0	0
Anesthesia Services 482.52	32	2	1	1
Nuclear Medicine Services 482.53	2	1	0	0
Outpatient Services 482.54	7	1	0	0
Emergency Services 482.55	42	3	3	3
Rehabilitation Services 482.56	9	1	0	0
Respiratory Care Services 482.57	25	1	3	3

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